**CONSENT FOR CARE**
**FOR ALL STUDENTS 17YRS. OR YOUNGER PARTICPATING IN UNIVERSITY AFFILIATED PROGRAMS.**

I understand that in accordance with Xavier University of Louisiana Policy a signed consent form from a parent or legal guardian must be on file at the University Health Services Center before providing treatment to minors who are attending or participating in University affiliated programs.

In that regard, I hereby request and authorize the Xavier University Student Health Services Center to provide:

Ariana Chretien | 900748777 | 07.16.2000
**(Print) Student/Participant Name** | **ID#** | **Date of Birth**

to receive health care services available and deemed necessary by the staff of the Xavier University Health Services Center. These services may include, but are not limited to, such procedures as evaluation and treatment of acute illnesses and injuries. Consent is specifically given for care in the event the above named minor student/participant presents him/herself for treatment in my absence. I also consent to Xavier University Health Services Center staff contacting any such persons or agencies for the purpose of providing or receiving information and records necessary for the care of the aforementioned minor student and will sign any necessary forms in that regard.

This Consent for Care is authorized for the length of time the participant is enrolled in the University. I may choose to withdraw the consent at any time by contacting Xavier University of Louisiana Student Health Services Center in writing. My permission is hereby given to Xavier University of Louisiana, through its appointed representative(s) to use discretion in providing, at my expense (personal / insurance, etc.) emergency care.

Parent/Guardian's Name (Print): Chretien (Last) April (First) F (MI)

Parent/Guardian's Signature: Chretien (Last) April (First) F (MI) 07.3.18 (Date)

Home Phone: (281) 580-4974 Cellular Phone: (832) 492-6167

**EMERGENCY CONTACT INFORMATION:**

Name (Print): Chretien (Last) Carl (First) B (MI) Father (Relationship)

Home Phone: (281) 580-4974 Cellular Phone: (832) 492-6165

Name (Print): Forbes (Last) Bestine (First) E (MI) Grandmother (Relationship)

Home Phone: (713) 734-4576 Cellular Phone: (713) 419-8606

**XAVIER UNIVERSITY OF LOUISIANA**
1Drexel Drive Box 36
New Orleans, La. 70125
Office: (504)520-7396 Fax: (504)520-7962

# Required Immunizations

**(Louisiana R.S. 17:170 Schools of Higher Learning)**

STUDENT COMPLETES

Student ID# 900248222 (or SSN #) Fall 18 Spring ____ Summer ____ 20____

Name: Chretien (LAST) Ariana (FIRST) Chanta-Danielle (MIDDLE)

Birth Date: 07/16/2000 Age: 17 Sex: F 2 On Campus ____ Off Campus

Home Address: 14307 Torrey Vista (P.O. BOX / STREET) Houston (CITY) TX (STATE) 77014 (ZIPCODE)

Home Phone: (281) 580-4994 Cellular Phone: (713) 594-4299 E-mail: arianachretien@gmail.com

MUST BE COMPLETED, SIGNED & STAMPED BY HEALTHCARE PROVIDER

Two (2) doses of MMR required at least 28 days apart. 1st dose after 12 months of age. If born prior to 1957 vaccine not required.

MMR#1 _____ DATE MMR#2 _____ DATE

OR

MEASLES (RUBEOLA) #1 _____ DATE

#2 _____ DATE

MUMPS#1 _____ DATE

MUMPS#2 _____ DATE RUBELLA _____ DATE

OR

COPY OF SEROLOGIC TEST (Titers)

**TD, T-dap**
Dose must be within last 10 years. (T-dap recommended)

_____ DATE

**MENINGITIS**
(Quadrivalent vaccine A, C, Y, W-135) One (1) dose required at 16yrs. of age or older. 55yrs. or older vaccine not required.

_____ DATE

**RECOMMENDED IMMUNIZATION(S)**

**VARICELLA (2 DOSES)**

VARICELLA#1 _____ DATE VARICELLA#2 _____ DATE

**HEPATITIS B (3 DOSES)**

HEPATITIS#1 _____ DATE HEPATITIS#2 _____ DATE

HEPATITIS#3 _____ DATE

Provider Signature: _____ Date: ____/____/____

CLINIC STAMP

Address: _____ Phone#: (  ) _____

**Tuberculosis (TB) Questionnaire (Please answer the questions below)**

Have you ever had a positive TB skin test, if yes **STOP** here: Have your physician send a statement documenting the date of positive Tb test, copy of last chest x-ray or IGRA report and your present health status.

| | | |
|---|---|---|
| 1. Have you ever had close contact with somebody ill with TB? | ☐ Yes | ☐ No |
| 2. Have you visited Africa, East Europe, Asia, Middle East or South/Central America in the last six months? | ☐ Yes | ☐ No |
| 3. Have you been an employee or volunteer in a prison, nursing home, homeless shelter or hospital? | ☐ Yes | ☐ No |
| 4. Do you take immunosuppressive medications that suppress the immune system? | ☐ Yes | ☐ No |
| 5. Do you have AIDS/HIV? | ☐ Yes | ☐ No |

If the answer to all the above questions is **NO**, no further action is required.
If the answer is **YES** to any of the questions 1 – 5, you must obtain Tb testing.

**Tuberculin Skin Test**: **(Must be done within 6 months of this registration)**

**Date applied**: ____/____/____ Date read: ____/____/____ **Injection Site**: _____ Lot #: _____ Manufacturer: _____

**Result**: _____mm of induration **Interpretation**: Negative ____ Positive ____ **(IGRA is required if PPD is positive; if IGRA is positive a Chest X-ray is required)**

**PPD Interpretation Guideline**

≥ 5 mm is positive: Recent close contact with person with active TB, Abnormal CXR c/w past TB disease, Organ transplant or other immunosuppression illicit drug use HIV/AIDS

≥10 mm is positive: Significant travel or residence in high prevalence area, Worker in healthcare, homeless shelter, prisons, Chronic health issues, as per screening questions

≥15 mm is positive if no risk factors

Provider Signature: _____ Date: ____/____/____

CLINIC STAMP

Address: _____ Phone#: (  ) _____

Texas Children's Pediatrics

Texas Children's Pediatrics Cypresswood
8111 Cypresswood
Ste 104
Spring TX 77379
281-376-0707

## Patient Information

| Patient Name | | DOB |
|---|---|---|
| Chretien, Ariana D | XUIA ID: 900748222 | 7/16/2000 |

## Current Immunizations

Reviewed on 6/29/2018

| Name | Date |
|---|---|
| **DTaP** | 8/10/2005, 8/11/2004, 1/7/2002, 2/7/2001, 11/29/2000, 9/13/2000 |
| **HepA** | 8/1/2003, 10/1/2002 |
| **HepB** | 7/27/2001, 4/3/2001, 2/7/2001 |
| **Hib** | 1/7/2002, 2/7/2001, 11/29/2000, 9/13/2000 |
| **IPV** | 8/10/2005, 8/11/2004, 7/27/2001, 11/29/2000, 9/13/2000 |
| **Influenza IIV3 PF** | 11/20/2007 |
| **Influenza LAIV3** | 8/24/2012, 11/5/2010 |
| **Influenza LAIV4 Nasal** | 11/21/2014, 12/11/2013 |
| **MCV4 (Menactra)** | 6/29/2017, 8/23/2011 |
| **MMR** | 8/10/2005, 8/11/2004, 7/27/2001 |
| **Meningococcal B, Fully Recomb (Trumenba)** | 6/29/2017 |
| **PCV7 (Prevnar)** | 2/7/2001, 11/29/2000, 9/13/2000 |
| **Tdap** | 8/23/2011 |
| **VAR** | 11/20/2007, 7/27/2001 |

Sherri Sandifer MD