XAVIER UNIVERSITY

INSTRUCTIONS

University: **Xavier University**

Student: DOB:

HOW TO COMPLETE THESE FORM(S):

- ☐ A licensed healthcare professional **MUST** complete and sign **THESE** forms. **ALL green sections are required.**
- ☐ **PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- ☐ **NO** other forms of documentation will be accepted. (Blue Cards, Yellow Cards, State Immunization Records, etc. are NOT accepted)
- ☐ Do not fold, cut, or mark on the border lines of these forms.
- ☐ Include the Border Lines in your scanned images.
- ☐ Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- ☐ Consult your Healthcare Professional before receiving any of the following immunizations.

Your records are due by: First day of class

REQUIRED

Required by regulation and /or policy to attend this university.

Documents:

Immunization Certificate

Immunization Dates:

Men A/C/W/Y (1 dose @ age 16 or older)
Hepatitis B (3 doses OR Pos. Quant. Titer)
MMR (2 doses OR Pos. Titer)
COVID-19 - "up to date" as defined by the CDC.

**All International Students have the additional requirement of Two-Step Tb Results **

RECOMMENDED

Recommended for your general well being but NOT required.

Immunization Dates:

Meningococcal B
Two-Step Tb Results
Varicella
Polio
Hepatitis A
TDaP Booster
HPV

OPTIONAL

Optional information

Immunization Dates:

JE - Japanese Encephalitis
Typhoid
Yellow Fever
Rabies

UPLOADING YOUR FORMS:

- ☐ Review your forms for completeness and accuracy. **Double check ALL signatures.**
- ☐ Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- ☐ Upload your completed forms to your account at medproctor.com.
- ☐ You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- ☐ Check your University Email account regularly for messages from MedProctor regarding incomplete information.

You will be notified via email once your information is successfully verified.

BE AWARE:

* Incomplete/Illegible writing and poor images will be rejected.
* Completion of these forms by your due date will help expedite your registration process.

Do not upload this page.

IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

University: **Xavier University**

Student: DOB:

Green = Required
Blue = Recommended
Black = Optional

MMR Measles, Mumps, Rubella — Required
1st M M D D Y Y
2nd M M D D Y Y

MENINGOCOCCAL — Required
1st M M D D Y Y
2nd M M D D Y Y

COVID-19 — Required
1st: M M D D Y Y
2nd: M M D D Y Y
3rd: M M D D Y Y

HEPATITIS B — Required
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

HPV - Human Papillomavirus — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

TDaP / TD - Booster — Recommended
Within 10 yrs. M M D D Y Y
TDaP ○ TD ○

VARICELLA - Chicken Pox — Recommended
1st M M D D Y Y
2nd M M D D Y Y

HEPATITIS A — Recommended
1st M M D D Y Y
2nd M M D D Y Y

POLIO - Inactivated — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y
4th M M D D Y Y

Typhoid - Inactivated — Optional
One M M D D Y Y

Yellow Fever — Optional
One M M D D Y Y

RABIES - Pre-Exposure — Optional
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

MENINGOCOCCAL B — Recommended
1st M M D D Y Y
2nd M M D D Y Y

REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

RECOMMENDED - Two-Step Tuberculosis Test Results (7 to 21 days apart) OR Tuberculosis Blood Test Results

1st Tb Skin Results PPD
Placed: M M D D Y Y
Read: M M D D Y Y
actual induration in MM only: m m

2nd Tb Skin Results PPD
Placed: M M D D Y Y
Read: M M D D Y Y
actual induration in MM only: m m

OR

Tb Blood Test T-Spot QuantiFERON — Results + ○ - ○
M M D D Y Y

Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE M M D D Y Y
NPI NUMBER	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

OFFICE STAMP

Last edited 5-12-22.