XAVIER
UNIVERSITY OF LOUISIANA

Re-entry Request Form
Medical Emergency Withdrawal

This form must be completed by the student and submitted to their healthcare provider prior to requesting their healthcare provider release required medical documentation to the Vice President Office of Student Affairs.

Section 1: Student Information: Please Print

Date: _____ Student ID# _____

Name: _____DOB: _____

Address: _____
Street **City** **State** **Zip Code**

Date/Semester medical leave began: _____

Desired Date/Semester returning: _____

Section 2: Student Statement and signature:

I understand my completed re-entry form and required supporting medical documentation (see below) from my licensed healthcare provider (MD, DO, Psychologist, Psychiatrist) must be submitted within 30 days prior to the start of the first day of classes for the semester petitioned for re-entry. Once the completed re-entry form and required supporting medical documentation is received and reviewed by the withdrawal health advisory committee a recommendation for re-entry will be submitted to the VP of Student Affairs for final approval. **Note: Required Medical Documentation must come directly from the licensed healthcare provider to the VP of Student Affairs Office.**

Required Medical Documentation

- Letter stating medical condition with diagnosis
- Compliance with stated treatment plan
- List of medications if prescribed
- Plans for follow-up care including recommendation for continuing medical treatment and support that may be requested from University Counseling Center or Student Health Services.

Student Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(if 17y/o or younger)

Section 3: Release of Medical Information Consent:

I authorize _____ the release/disclosure of the following
Licensed Healthcare Provider Name

protected health information: **Place an "X" in the box (es) that apply to the information to be released.** □ Entire Record □ Medical History, Examination, Reports □ Surgical Reports □ Treatment or Tests □ Prescriptions □ Hospital Records including Reports □ Laboratory Reports □ X-ray Reports □ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

□ Alcoholism □ Drug Abuse □ Mental Health □Vocational Rehabilitation □ HIV (AIDS)

□ Sexually Transmitted Diseases □ Psychotherapy Notes

The Purpose of this Authorization is to allow the sharing of my protected health information regarding my mental health and/or medical issue (s) that pertains to my medical emergency withdrawal.

This authorization shall expire on _____ (date) and

is needed for the period beginning _____and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I also understand that I may revoke this authorization at any time and must do so in writing. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Patient/Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(if 17y/o or younger)

Witness Signature: _____ Date: _____

Section 4: Licensed Healthcare Provider Information:

Mental Health - healthcare provider must be a **licensed psychologist or psychiatrist**
Medical – healthcare provider must be a **licensed medical physician**

Name: _____ Licensed as: _____

License number and State: _____

Address_____
Street City State Zip Code

Office Phone: _____ Office Fax: _____

Section 5: Licensed Healthcare Provider Section:

Date of initial visit: _____ Date of most recent visit: _____
Total number of times you have seen the student: _____ Diagnosis: _____
Treatment modalities provided: □Psychotherapy □Pharmacotherapy

Please provide your professional judgement in response to the following questions regarding the above named student.

Has there been a substantial improvement of the student's original medical/psychological condition?
□Yes □No **If yes, please check all of the following that you have observed a marked reduction of in this student:** □Number of symptoms □Severity of symptoms □Persistence of symptoms

□ Functional impairment □Subjective level of client distress

For how long has the improved condition been maintained? _____

_____

What evidence has been demonstrated to suggest that the student has increased ability to manage academic life and live independently in the residence halls?

_____

_____

Does the student appear capable of functioning autonomously and successfully in a rigorous full-time academic environment? □**Yes** □**No** Comments: _____

_____

Is continued treatment recommended and if so will the student have these recommendations in place at the time of potential return to campus? □**Yes** □**No** Comments: _____

_____

Please (√) check one of the boxes and provide explanation in the Comments section below.

In my professional judgement in response to the above questions regarding the above named student:

Student ability to resume full-time academic enrollment and residential living or off –campus living:

- **Academic responsibility** may consist of 12-15 credits of rigorous academic course loads, extracurricular activities with leadership responsibilities, and possible athletics and/or research involvement.
- **Residential/ Off-campus living** is either alone or with roommates; where student must maintain all activities of daily living without supervision.

□ Student is ready to resume full-time academic enrollment and residential living if available.

□ Student is ready to resume full-time academic enrollment but not residential living.

□ Student is ready to be placed on Medical Interim Restriction and residential living, if available. Restriction will continue until further notice from current healthcare provider.

□ Student may be placed on Medical Interim Restriction but not residential living.

□ Student is not ready to resume fulltime academic enrollment at this time.

Comments: _____

_____

_____

My response to each of the questions listed above is true, complete, and accurate to the best of my knowledge and belief, my signature below constitutes my best professional judgement and /or opinion regarding the current medical and/or mental health status of the above named student.

Healthcare Provider Signature: _____ **Date:** _____

Please mail completed form to: Xavier University of LA: **Office of Student Affairs**: **Attn:** VP of Student Affairs:
1 Drexel Drive • P.O. Box 29: New Orleans, LA 70125: Office: (504)520-7357 Fax: (504)520-7929