STUDENT HEALTH SERVICE
450 CLARKSON AVENUE, MSC 33
BROOKLYN, NEW YORK 11203-2098
(718) 270-2018/1995 • FAX (718) 270-2901/2477

Date of Birth ________________

Date __________

STUDENT IMMUNIZATION AND LABORATORY RECORD

Student's Name____ Program________________
PRINT CLEARLY PRINT CLEARLY

The following immunizations and laboratory tests are required by NY State Health Code and by this school. <u>COPIES OF LABORATORY SLIPS MUST BE SUBMITTED</u>.

Tuberculin Testing Date given:_________ Date read:________

Mantoux test required within **6 months** of matriculation or blood based tuberculin testing

(Attach copy of results)

(Prior history of BCG is <u>not</u> acceptable as proof of positive PPD)

Lot # and manufacturer:_________________

Result:____________________ mm induration

If positive tuberculin, Date ___________. Treatment: Yes/No Medication(s) given: ________________________

____ Treatment Dates: ____________________________

Chest X-ray
PA and lateral views *if tuberculin or* blood-based tuberculosis test *is positive.* Chest X-ray must be done after the positive test.

<u>Official radiologist's report of chest x-ray result must be submitted.</u>

Polio Vaccine Series Dates:_______________, ______________ ,____________ , _______________

Tdap (tetanus, diphtheria, acellular pertussis) for adolescents and adults within the past 10 years ________________________. Or specify medical contraindication:____________________, and date of Td_________________ within the past ten years. Primary TDP series dates:
___________, ___________,_________ , ___________

MMR Immunization with 2 doses of measles, mumps, rubella (MMR) vaccine (or equivalent) is required with first dose on or after the first birthday; second dose at or after 15 months of age and at least 30 days after the first dose.

Dates:_____________ ____________
Dose1 Dose2

or positive measles, mumps, rubella titers done at any time (attach copy of lab results).

PLEASE TURN OVER

Student's Name

Varicella (chicken pox)

Antibody titer **(must submit lab slip to verify)** must be positive or

Varicella vaccine must be given (2 doses required) ____________ ____________
Date of dose1 Date of dose2

Hepatitis B vaccine dates: ________ ________ ________
1 **2** **3**

Hepatitis B surface antigen________ **quantitative** surface antibody________ Date of test ____________
pos/neg **pos/neg**

SUBMIT COPIES OF LAB SLIPS

Laboratory Studies (submit copies of lab slips)

Complete Blood Count—Date and Result____

Urinalysis—Date and Result____

Optional Vaccines: Hepatitis A _______, ______ **HPV** _________ , ___________ , ___________
Typhoid oral _____________ **Typhoid injection** ______________

Name of physician/provider (PRINT)____

Address____

Signature of physician/provider______________________________ Telephone____________________

State and license number of physician/provider ____

THE DEADLINE FOR SUBMISSION OF COMPLETETED HEALTH FORMS IS ONE MONTH PRIOR TO YOUR MATRICULATION (REGISTRATION & ORIENTATION) DATE! STUDENTS WILL NOT BE ALLOWED TO REGISTER AND MATRICULATE WITHOUT HEALTH CLEARANCE!!