

OFFICE USE ONLY:

Date Entered: _____

School of the Sciences Supplemental Health Form

Please contact Missy Craig if you have questions regarding the completion of this form- 443-334-2282 Carriage House 217, Greenspring Campus

TO BE COMPLETED BY ALL JUNIOR/SENIOR NURSING & JUNIOR/SENIOR MEDICAL TECHNOLOGY STUDENTS

Students should mail/fax this sheet along with required supporting documents to Missy Craig by July 1st. If it is not on file in the School of the Sciences you will be dropped from all clinical Nursing or all Medical Technology courses.

Name: _____			
Last	First	Middle	
Date of Birth: ____/____/____		Student ID #: _____	
Mo.	Day	Year	

I. One Time Requirement for duration of academic program- Please include a copy of the positive lab results for the required titers:

Titers	Lab Results Attached (check)
MMR	<input type="checkbox"/>
Varicella	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>

Immunization	Date Administered	Copy of Documentation Attached (check) <u>or</u> Provider Initials*
Td or Tdap (within 5 years)	____/____/____	<input type="checkbox"/> _____ Initials

II. Annual Requirements- Please complete section which applies to the year you are entering. You are responsible for providing this information each year you are in clinical. NOTE: The Wellness Center runs PPD Clinics during the months of May and November. Please contact the Wellness Center in order to get more information and to schedule an appointment.

Nursing

PPD	DATE ADMINISTERED	Date Read	Result (mm)	Neg./Pos.	Copy of Documentation Attached (check) <u>or</u> Provider Initials*	Proof of Insurance	Copy of Insurance Card Attached (check)
JUNIOR YEAR	____/____/____	____/____/____	____	____	<input type="checkbox"/> _____ Initials	JUNIOR YEAR	<input type="checkbox"/>
SENIOR YEAR	____/____/____	____/____/____	____	____	<input type="checkbox"/> _____ Initials	SENIOR YEAR	<input type="checkbox"/>

Medical Technology

PPD	DATE ADMINISTERED	Date Read	Result (mm)	Neg./Pos.	Copy of Documentation Attached (check) <u>or</u> Provider Initials*
SENIOR YEAR	____/____/____	____/____/____	____	____	<input type="checkbox"/> _____ Initials

*Practitioner's signature (required) _____ Date: _____

Print or stamp name _____ Fax number: _____

Address: _____
Street Number
Street Name
City
MD
Zip Code