

Supplemental Health Form – Medical Laboratory Science

TO BE COMPLETED BY ALL JUNIOR & SENIOR STUDENTS

Return the signed form and required supporting documents by **July 1st** to Ms. Lara Biagiotti, Clinical Education Technologist, Medical Laboratory Science Program, Sinai Hospital, 2401 West Belvedere Avenue, Baltimore, MD 21215 or e-mail the form and documents to lbiagiot@lifebridgehealth.org or lbiagiotti@stevenson.edu
 If completed form is not received by **July 1st**, you will be dropped from all MLS courses. **Incomplete forms will not be accepted.**
 If you have questions regarding the completion of this form, please contact Ms. Lara Biagiotti: lbiagiot@lifebridgehealth.org or call 410-601-1112.

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

YOUR HEALTH CARE PROVIDER MUST UPDATE IMMUNIZATIONS TO MEET UNIVERSITY REQUIREMENTS. THE FOLLOWING MEDICAL INFORMATION MUST BE:

- **COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER**
- **MEDICAL DOCUMENTS MUST ACCOMPANY THIS HEALTH FORM**

	Dose 1 12 months after birth or later	Dose 2 At least 3 months after dose #1	Positive Titer Copy of laboratory test result MUST be attached
Varicella (Chicken Pox)	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.
Measles, Mumps, Rubella (MMR)	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.

	Dose 1	Dose 2	Dose 3
Tdap <i>Within 10 years</i>	____/____/____ Mo. Day Yr.		
Hepatitis B Series	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.

Anti-HBs Titer - Copy of lab test result MUST be attached	
Date: ____/____/____ Mo. Day Yr.	Immune: ___ Yes ___ No If non-immune, student MUST receive 1 booster and repeat titer within 1-2 months after booster dose.

Tuberculin Skin Test (PPD): SENIOR STUDENTS ONLY

PPD	Date Administered	Date Read	Negative/Positive	Documentation Attached <input checked="" type="checkbox"/> OR Provider Initials
SENIOR YEAR	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	___	<input type="checkbox"/> _____ Initials

Provider signature (required) _____ Date: _____

Print or stamp name _____ Fax number: _____

Address: _____
 Street Number, Street Name City State Zip Code