SCHOOL of HEALTH PROFESSIONS
STEVENSON UNIVERSITY
MEDICAL LABORATORY SCIENCE

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	**Diagnosis *or* history of disease**	**Positive Titer** Copy of laboratory test result **MUST** be attached
Varicella (Chicken Pox)	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**
Measles, Mumps, Rubella (MMR)	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**

	Dose 1	**Dose 2**	**Dose 3**
Tdap Within 10 years	___/___/___ **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: ___/___/____ Immune: ___ Yes ___ No **If non-immune, student MUST receive 1 booster and repeat titer *within 1-2 months* after booster dose.**
Mo. Day Yr.

Tuberculin Skin Test (PPD): SENIOR STUDENTS ONLY

PPD	**Date Administered**	**Date Read**	**Negative/Positive**	**Documentation Attached ☑ *OR* Provider Initials**
SENIOR YEAR	___/___/___ **Mo. Day Yr.**	___/___/___ **Mo. Day Yr.**	____	☐ ____ **Initials**

Provider signature (required) _____ **Date:** _____

Print or stamp name _____ **Fax number:** _____

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