# 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 lbiagiot@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.

---

**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**

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Positive Titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months after birth or later</td>
<td>At least 3 months after dose #1</td>
<td>Copy of laboratory test result MUST be attached</td>
</tr>
</tbody>
</table>

- **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.

- **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.

---

**Tuberculin Skin Test (PPD):** **SENIOR STUDENTS ONLY**

<table>
<thead>
<tr>
<th>PPD</th>
<th>Date Administered</th>
<th>Date Read</th>
<th>Negative/Positive</th>
<th>Documentation Attached</th>
<th>Provider Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>SENIOR YEAR</td>
<td><em><strong>/</strong></em>/___</td>
<td><em><strong>/</strong></em>/___</td>
<td>___</td>
<td>□</td>
<td>___</td>
</tr>
<tr>
<td></td>
<td>Mo.  Day  Yr.</td>
<td>Mo.  Day  Yr.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider signature (required) ___________________________ Date: __________

Print or stamp name ___________________________ Fax number: ___________________________

Address: ____________________________________________

Street Number, Street Name City State Zip Code