Student Name: _____ **Date of Birth:** _____

THIS SECTION COMPLETED BY HEALTH CARE PROVIDER

REQUIRED:

MMR #1____/____/____ **MMR** #2____/____/____ **OR** *ATTACH LAB RESULT SHOWING IMMUNE STATUS*

MENINGOCOCCAL VACCINE: (Required by the State within in the last 5 years)

CIRCLE ONE: Menactra, Menveo, ACWY, Men B Series **AND** SIGN ENCLOSED MENINGITIS RESPONSE FORM.
#1____/____/____ #2____/____/____ #3____/____/____ Trumemba or Bexsero

COVID-19 VACCINE:

Moderna #1 ____/____/____ #2____/____/____
Pfizer #1 ____/____/____ #2____/____/____
Johnson & Johnson (Janssen) #1____/____/____
____ I wish to apply for vaccine exemption. (See Le Moyne Health Services Webpage)

RECOMMENDED:

INFLUENZA: VACCINE DATE ____/____/____
COVID BOOSTER: ___/___/___ VACCINE NAME: _____
VARICELLA VACCINE: VACCINE DATES #1 ____/____/____ #2____/____/____
HEPATITIS B SERIES: VACCINE DATES #1____/____/____ #2____/____/____ #3____/____/_____
TETANUS (ADULT) BOOSTER: **TDAP** DATE: ____/____/____ (WITHIN THE PAST 10 YEARS)
HPV #1____/____/____ #2____/____/____ #3____/____/_____

TUBERCULOSIS SCREENING QUESTIONNAIRE

1. Does the student have signs or symptoms of active tuberculosis disease? Yes____ No____ **If No, proceed to 2**.
   If Yes, proceed with additional evaluation to exclude active TB including; Tuberculin skin testing, chest X-ray and sputum evaluation as indicated.
2. Is the student a member of a ***high-risk group?** Yes___ No___ **If No, STOP**. **If Yes, proceed with skin testing**.
   A history of BCG vaccination does not preclude testing of a high-risk member.
   2a) Tuberculin Skin Test (Mantoux only and within past year) ***Only required if high risk or active TB***
   Date given: _____ Date read: _____ Result (in actual mm induration) _____
   PPD manufacturer, Lot # and Expiration date: _____
3. Chest X-ray (required if tuberculin skin test is positive)
   Results: Normal _____ Abnormal _____ Treatment: _____

*Categories of **high risk** students include those students who have arrived in the past 5 years from countries where TB is endemic. It is easier to identify countries of **low** rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries ***EXCEPT*** those on the following list: Canada, Jamaica, St. Kitts, and Nevis, Saint Lucia, Virgin Islands USA, Belgium, Denmark, Finland, France, Germany, Greece, Iceland Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters: and those who have clinical conditions such as diabetes, chronic renal failure, leukemia's, or lymphomas, low body weight, gastrectomy and jejunoileal by pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone>15mg/day for >1 month) or other immunosuppressive disorders.

PHYSICIAN OR HEALTH CARE PROVIDER (Must be signed and dated to be acceptable)

PRINTED NAME: _____ **ADDRESS:** _____

SIGNATURE: _____ **PHONE:** (_____)_____ **DATE:** _____