Icahn School of Medicine at Mount Sinai

Student Health Center

Mount Sinai
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574

Tel: (212) 241-6023
Fax: (212) 241-8008
studenthealth@mssm.edu

TUBERCULOSIS, VACCINATION AND TITERS RESPONSE FORM

PART I: TO BE FILLED OUT BY STUDENT
STUDENT INFORMATION

Student Name (First, Middle Initial , Last)	**Date of Birth** ___/___/____	**Telephone Number** ☐ HOME ☐ CELL

Address	**City**	**State**	**Zip**	**Email**

Gender ☐ Male ☐ Female	**Gender Identity** ☐ Male ☐ Female ☐ Other __________	**Gender Pronoun** ☐ He ☐ She ☐ They ☐ Name Only ☐ Other________

PART II: TO BE FILLED OUT BY PROVIDER
SCREENING FOR TUBERCULOSIS

Date PPD Planted: ________________________________ ☐ History of BCG Vaccine
(must be within 6 months)

Date PPD Read: __________________________________ Result: ______________mm

Interpretation: Positive [ ] Negative [ ]

OR

Quantiferon Gold TB test Date: ______________________ Result: ______________(***please provide copy***)

(must be within 6 months)

If Previously Positive:

Chest X-ray Date: ________________________________ Result: ______________(***please provide copy***)
(must be within 1 year)

VACCINATION AND TITERS HISTORY

THE FOLLOWING VACCINES AND LABORATORY TESTS ARE MANDATORY. PLEASE ATTACH THE POST IMMUNIZATION LAB RESULTS SHOWING:

	MMR	**Varicella**	**Hepatitis B**	**Tdap**
Dates	1. 2. **AND**	1. 2. **AND**	1. 2. 3. **AND**	**Must be within 10 yrs.** 1.
Titer (date/result) **complete & attach lab report results showing immunity**	Measles IgG Mumps IgG Rubella IgG	Varicella IgG	Hep B Surface Ab (QUANTITATIVE preferred)	No titers required

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Optional (Highly Recommended) Vaccines

The following vaccines are recommended. Please indicate vaccination date(s).

1. Hepatitis A Date(s): ______________ ______________
2. IPV Date(s): ______________
3. HPV Date(s): ______________ ______________ ______________
4. FLU (if attending between October - May) : ______________

Please also send us any other vaccines you have received for travel.

1. Vaccine: ____________________ Date(s): ____________________
2. Vaccine: ____________________ Date(s): ____________________
3. Vaccine: ____________________ Date(s): ____________________

Provider Signature and Information

Provider Signature: ____________________________ **Date:** ____________________________

Provider Stamp:

Name:
Address:
Telephone number:
Email:

Updated 01/5/17