



Resident Immunization Record

Name: _____

Date Submitted _____

Program: _____

Date of Birth _____

The following immunizations are **REQUIRED** by the State Health Code of New York and the hospital:
The following must be completed and signed by a health care provider.

Dear Health Care Provider:

1. If a titer is performed and shows no immunity, resident **must** be reimmunized.
2. If immunizations are needed, MMR vaccine is recommended because it provides protection against all three vaccine - preventable diseases (measles, mumps, and rubella).

Measles (rubeola): (Unless born prior to 01/01/1957)

• Rubeola titer done: Date: _____ Immune: Yes No Enclose copy of Laboratory Report

Rubella (german measles): Note: A physician's diagnosis of having had rubella is **not** acceptable.

• Rubella titer done: Date: _____ Immune: Yes No Enclose copy of Laboratory Report

Mumps: Note: A Physician's diagnosis of having mumps is not acceptable.

• Mumps titer done: Date: _____ Immune: Yes No Enclose copy of Laboratory Report

Varicella (chickenpox): One of the following indicators of immunity is required:

Varicella immunizations received:
Date: #1: _____
Date: #2: _____

OR

Varicella titer done:
Date: _____
Immune: <input type="checkbox"/> Yes <input type="checkbox"/> No
Enclose Copy of Laboratory Report

OR

History of having varicella :
<input type="checkbox"/> Yes <input type="checkbox"/> No

Tetanus: Highly recommended within past 10 years Vaccination date: _____

Hepatitis B: Highly recommended. Can be completed at SUNY Upstate Medical University

Dates: #1: _____ #2: _____ #3: _____

Antibody date (if done) _____ Results: _____

Previous Tuberculin Skin Testing: (TST) (within 12 months of starting)

• Date given: _____ Product Manufacturer: _____ Lot #/Expiration Date: _____

• Date read: _____ Results: _____

• **If previous TST was positive,** Date of conversion: _____ Reaction: _____ mm x _____ mm

• **Chest x ray is required** for those who are TST positive (required within 6 months of starting)

Date: _____ Result: _____ (Report must be enclosed)

• **Was treatment taken for a positive TST** Yes No

Drug: _____ Date Started: _____ Date Completed: _____

ALL NEW EMPLOYEES WITH A PRIOR NEGATIVE TUBERCULIN SKIN TEST WILL ALSO HAVE A PPD PLACED BY THE HEALTH OFFICE PRIOR TO STARTING.

Print name of Health Care Provider: _____ Title: _____

Signature of Health Care Provider: _____

Health Care Providers Address: _____ Telephone: () _____