BARNARD
Primary Care Health Service

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

TO BE COMPLETED & SIGNED BY YOUR HEALTH CARE PROVIDER THESE FORMS MUST BE UPLOADED BY

June 30, 2022

Address:
Barnard College
Primary Care Health Service
3009 Broadway, New York, NY 10027

Fax Number:
1-212-854-2702

Phone:
1-212-854-2091

Please upload forms to bchealth.barnard.edu

Name: _____ **Birth Date:** _____ / _____ / _____

REQUIRED PROOF OF MEASLES, MUMPS & RUBELLA IMMUNITY & COVID-19 VACCINATION

(2 MMR doses, individual Measles, Mumps, Rubella vaccinations OR titers mandated by NY law)

Combined MMR:

MMR Dose 1:
Must be given no earlier than 4 days before 1st birthday
Date: ____ / ____ / _____
Month Date Year
Exact Date Required

MMR Dose 2:
Must be given at least 28 days after 1st dose
Date: ___ / ____ / ___
Month Date Year
Exact Date Required

Individual Vaccines

Measles Dose 1:
Must be given no earlier than 4 days before 1st birthday
Date: ____ / ____ / _____
Month Date Year
Exact Date Required

Measles Dose 2:
Must be given at least 28 days after 1st dose
Date: ____ / ____ /_____
Month Date Year
Exact Date Required

Mumps:
Must be given no earlier than 4 days before 1st birthday
Date: ____ / ____ / _____
Month Date Year
Exact Date Required

Rubella:
Must be given no earlier than 4 days before 1st birthday
Date: ____ / ____ / _____
Month Date Year (*Exact Date Required)*

Serological Testing

Measles Titer:
Date: ____ / ____ / _____
Month Date Year *Exact Date Required*
Result: ☐ Immune ☐ Not immune

Mumps Titer
Date: ____ / ____ / _____
Month Date Year *Exact Date Required*
Result: ☐ Immune ☐ Not immune

Rubella Titer:
Date: ____ / ____ / _____
Month Date Year *Exact Date Required*
Result: ☐ Immune ☐ Not immune
Please attach official titer lab reports.

COVID-19 Vaccines

COVID Vaccine Dose 1:	COVID Vaccine Dose 2:	COVID Vaccine Booster Dose:
Date: _____ / _____ /_____	Must be given at least 3-8 weeks after 1st dose	Must be given at least 5 months after 1st dose
Month Date Year	**Date:** ____ / ____ / _____	**Date:** ____ / _____ / _____
Exact Date Required	Month Date Year	Month Date Year
Manufacturer: _____	Exact Date Required	Exact Date Required
	Manufacturer: _____	**Manufacturer:** _____

Name: _____ Tuberculosis Screening Form

If the answer is "YES" to ONE or MORE of the following questions, and you DO NOT have a history of a documented positive tuberculin skin or blood test, you must submit:

- A PPD/Mantoux skin test from within the last 6 months.
- Or the results of a T-Spot or Quantiferon Gold blood test from within the last 6 months.
  - A chest x-ray is required if the tuberculin skin test or blood test is positive.
- Even if you have had BCG, if the answer is "YES" to ONE or MORE of the questions below and you DO NOT have official documentation of a positive tuberculin skin or blood test and a negative chest x-ray, you must submit the results of a PPD/Mantoux skin test from within the last 6 months or the results of a T-Spot/Quantiferon Gold blood test from within the last 6 months. If your skin/blood test is positive you must submit a chest x-ray.

Required: Past Tuberculosis Testing:

1. Have you ever had a positive tuberculin skin test or blood test?

   ☐Yes ☐No

2. If you have had a positive tuberculin skin test or blood test, did you have a negative chest x-ray?

   ☐Yes ☐No ☐Not Applicable

3. If you have had a positive skin/blood test and a negative chest x-ray, have you been treated with INH?

   ☐Yes ☐No ☐Not Applicable

If yes, how long was your INH treatment?

_____

If you have ever had a documented positive tuberculin skin or blood test you must submit the following:

- Official documentation of the initial positive tuberculin test.
- Official report of a negative chest x-ray.
- If applicable, documentation of INH treatment dates.

You do NOT need to get an additional tuberculin skin/blood test or chest x-ray, unless you do not have official documentation of the initial skin or blood test & a negative chest x-ray.

Required: Tuberculosis Exposure Risk Factors:

1. Have you ever had close contact with anyone who was sick with TB?

   ☐Yes ☐No

2. Were you born in one of the countries listed?

   ☐Yes ☐No

3. Including childhood, have you ever traveled or lived in ANY of the countries listed for at least 1 month?

   ☐Yes ☐No

Please checkmark any country listed below if you have spent more than one (1) month in the country.

Africa

Algeria
Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
Congo
Congo, Democratic People's Republic of
Cote d'Ivoire
Djibouti
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Libya
Madagascar
Malawi
Mali
Mauritania
Morocco
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Somalia
South Africa
South Sudan
Sudan
Swaziland
Tanzania
Togo
Uganda
Zambia
Zimbabwe

Asia

Bangladesh
Bhutan
Burma (Myanmar)
Brunei Darussalam
Cambodia
China (excludes SARs and Taiwan)
East Timor
Fiji
Honk Kong (SAR of China)
India
Indonesia
Kiribati
Korea, Democratic People's Republic
D Korea, Republic of (South)
Laos
Macau (SAR of China)
Malaysia Maldives
Marshall Islands
Micronesia, Federated States of
Mongolia
Nauru
Nepal
Northern Mariana Islands
Pakistan
Palau
Papua New Guinea
Philippines
Singapore
Solomon Islands
Sri Lanka
Thailand
Tuvalu
Vietnam

Middle East

Afghanistan
Iraq
Qatar
Yemen

Europe, Russia, & Eurasia

Armenia
Azerbaijan
Belarus
Bosnia and Herzegovina
Georgia
Greenland
Kazakhstan
Kyrgyzstan
Lithuania
Latvia
Moldova
Romania
Russian Federation
Tajikistan
Turkmenistan
Ukraine Uzbekistan

Central America, South America & the Caribbean

Bolivia
Brazil
Dominican Republic
Ecuador
Guatemala
Guyana
Haiti
Honduras Nicaragua
Panama
Paraguay
Peru

Primary Care Health Service

Name: _____ Birth Date: _____ / _____ / _____

RECOMMENDED VACCINATIONS (CONT. ON PAGE 3)

HPV:

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

Dose 3: _____/_____/_____

MENINGOCOCCAL:

Dose 1: _____/_____/_____

Booster: _____/_____/_____

IMPORTANT:

You MUST submit the **electronic "Meningococcal Meningitis Vaccination Response Form (18 or OVER)"** or the paper-based **"Under 18: Meningococcal Meningitis Vaccination Response Form"** (if you are 17 years old or younger), regardless of if you receive the vaccine.

MENINGOCOCCAL B:

Brand: _____

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

Dose 3: _____/_____/_____

HEPATITIS A:

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

OR

Titer Date: _____/_____/_____

☐ Immune ☐ Not immune

TETANUS-DIPHTHERIA-PERTUSIS:

Primary series with DTaP or DTP and booster with Td in the last 10 years meets requirement.

Completed Basic Series of 4 Doses w/ DTaP or DTP: ☐Yes ☐No

Tdap Date (must be after 2005):

_____/_____/_____

Tdap was licensed in the United States in 2005. The U.S. brand names are Adacel and Boostrix.

Last Td (Tetanus and Diphtheria) Date: _____/_____/_____

HEPATITIS B:

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

Dose 3: _____/_____/_____

OR

Titer Date: _____/_____/_____

☐ Immune ☐ Not immune

PNEUMOCOCCUS:

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

POLIO:

Primary series in childhood meets requirement; three primary series schedules are acceptable.

Completed Basic Series: ☐ Yes ☐No

Last Polio Date: _____/_____/____

☐IPV ☐OPV

VARICELLA:

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

OR

Titer Date: _____/_____/_____

☐ Immune ☐ Not immune

OR

History of Disease: _____/_____/_____

OTHER VACCINES:

Ex. BCG, Typhoid (Oral or Injectable), Rabies (IM, ID or Immunoglobulin), Yellow Fever, Japanese Encephalitis, etc.

Please attach a copy of an official immunization record showing the vaccine dates.

Primary Care Health Service

Name: _____ Birth Date: _____ / _____ / _____

TUBERCULOSIS SCREENING:

You MUST complete the "Tuberculosis Screening Form" located in this packet PRIOR to completing this section.

• If you have ever had a documented positive tuberculin skin/blood test you must submit official documentation of:

o The initial positive tuberculin test.

o Report of a negative chest x-ray and if applicable, INH treatment plan.

• If you do not have official documentation of the initial skin/blood test AND a negative chest x-ray, you will need to get another skin or blood test and if necessary, chest x-ray.

******PLEASE ATTACH ALL OFFICIAL DOCUMENTATION & REPORTS TO THIS FORM******

• If the answer is "YES" to ANY of the questions on the "Tuberculosis Screening Form" and you DO NOT have a history of a documented positive tuberculin skin/blood test you must submit:

o A PPD skin test from within the last **6 months** or a Quantiferon Gold/T-Spot blood test from within the last **6 months**.

o If the blood or skin test is positive, you must submit proof of a negative chest x-ray.

o **Even if you have had BCG**, if the answer is "YES" to ANY of the questions and you DO NOT have documented history of a positive tuberculin skin/blood test AND a negative chest x-ray you must submit a PPD skin test from within the last 6 months or a Quantiferon Gold/T-Spot blood test from within the last 6 months, and if necessary a chest x-ray.

OR

Date PPD Administered: ____/____/____ Date PPD Read: ____/____/____ **Result**: □ Positive □ Negative **AND** _____mm induration	Date of Quantiferon Gold or T-Spot Test: ____/____/____ **Result**: □ Positive □ Negative **Please attach official lab report.**

If indicated by positive tuberculin skin/blood test

Date of Chest X-Ray: ____/____/____

Result: □ Normal □ Abnormal

INH Start Date: ____/____/____ Duration: _____

Please attach official x-ray report.

HEALTH CARE PROVIDER'S INFORMATION:

Please Note: The health care provider cannot be a relative of the student

(Please note that the only acceptable signatures are that of a physician, physician assistant or nurse practitioner.)

Provider's Name & Title: _____

Please circle: MD/DO PA NP

Signature: _____

Address:

_____

Telephone: _____

Provider Stamp