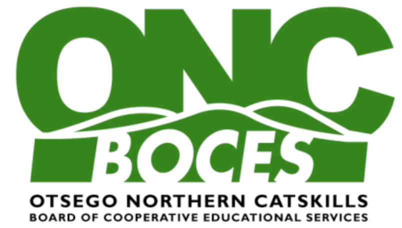

Adult Education

ONC BOCES Practical Nursing Program
Otsego Area School of Practical Nursing
31 Center Street – Third Floor
Oneonta, New York 13820
607-431-2562
FAX: 607-431-2563

IMMUNIZATION AND LABORATORY RECORD

Name______________________________ Date_________________ D.O.B.__________________

Please indicate dates for the following vaccines, titers, and diseases where applicable:
****If TITERS are used, a lab report of the titer MUST be submitted.**

Tuberculosis Skin Test: (First semester PPD results MUST be dated after 12/01/2019).

If this is your first time in Health Care you MUST have the TWO STEP PPD or show proof of a previous PPD.

PPD #1: Date Given ________ Date Read _________ List actual MM _________

Results: _____________________ Read by:___________________________(Print)

Read by: ___________________________(Signature and Title)

PPD #2: Date Given ________ Date Read _________ List actual MM _________

Results: _____________________ Read by:___________________________(Print)

Read by: ___________________________(Signature and Title)

***If PPD is positive or there is a history of a positive PPD, a chest x-ray is necessary within two years of start date or QuantiFERON-TB Gold Test results. Please send report to above address.

Rubella (German Measles) Immunity: (If titers are done a copy of the lab results must be submitted)

Immunization Date:_____________ Immunization Date:_____________ or

Titer:___________________ Date:____________ Results:____________

Measles (Rubeola): For all students born after January 1, 1957.
(If titers are done a copy of the lab results must be submitted)

Immunization Date:_____________ Immunization Date:_____________ or

Titer:___________________ Date:____________ Results:____________

Mumps Immunity: For all students born after January 1, 1957.
(If titers are done a copy of the lab results must be submitted)

Immunization Date:_____________ Immunization Date:_____________ or

Titer:___________________ Date:____________ Results:____________

(OVER)

Tetanus/Diphtheria/Pertussis:

Tdap Date Given: ______________________(Within last 10 years)

Varicella: (If titers are done a copy of the lab results must be submitted)

Immunization Date:_____________ Immunization Date:_____________ (MUST have 2 Immunizations)

Titer:___________________ Date:____________ Results:____________

Date of Illness:____________

Hepatitis B Vaccine Series with follow up Titer recommended or Titer: (A copy of the titer results must be submitted)

Date Given:_____________Date Given:_____________Date Given:_____________

Titer:___________________ Date:____________ Results:____________

Influenza Vaccine for upcoming 2020 – 2021 Flu season: (A copy of the administration record is required) A waiver may be signed and then the student MUST follow the facility policy for non-immunization during the New York State Flu Season.

Immunization Date:_____________

Healthcare Provider Name (PLEASE PRINT):___________________________

Healthcare Provider Signature: ____

Date:____

Hegis Code: 5209.20