Department of Education

REQUEST FOR REVIEW OF SEROLOGY or DOCUMENTATION OF VARICELLA DISEASE TO SATISFY IMMUNIZATION REQUIREMENTS

FOR DOE USE ONLY

Student's name _____ DOB ____/____/____

OSIS # | | | | | | | | | ATS DBN | | | | | |

TO BE COMPLETED BY THE HEALTH PROFESSIONAL

INFORMATION:

New York State Public Health Law §2164 allows for documentation of immunity to satisfy the immunization requirements for school attendance. Such documentation is accepted for:

MEASLES MUMPS RUBELLA VARICELLA HEPATITIS B POLIOMYELITIS (all three serotypes)

Blood tests are *NOT* accepted by New York State for diphtheria, tetanus or pertussis. Any such request will not be considered.

A history of varicella disease (chicken pox) documented by a licensed physician, nurse practitioner or physician assistant will satisfy the requirement for varicella.

INSTRUCTIONS:

Please attach:

- A printout of the child's immunization history page from the Citywide Immunization Registry that demonstrates reporting of disease/immunity, *OR*
- A copy of the laboratory result including the student's name, DOB, test results and reference range

_____ DOB ___/___/___ CIR ID | | | | | | | | | |

Student's name (PRINT)

I am the student's treating health care practitioner

NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Practitioner's original signature _____ Degree: _____ License # | | | | | | | | |

_____ Attending physician

_____ Nurse practitioner

_____ Fellow _____ Resident

Stamp

Contact information:

Direct telephone line __/__/__ __/__/__ __/__/__/__ ext __/__/__/__ Cell __/__/__ __/__/ __/__/__/__ Other _/__/__ __/__/__ __/__/__/__

PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

I authorize _____ (health professional) to provide physicians and nurses of the New York City Department of Health and Mental Hygiene and the New York City Department of Education and their medical consultants with information contained in my child's medical record, including, but not limited to, copies of laboratory and or other examinations supporting this request for medical exemption for required immunizations.

Parent/Guardian's signature _____

Parent/Guardian's name (PRINT) _____ Date _____

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Proof of immunity (serology) confirmed for (circle): Measles Mumps Rubella Varicella Hepatitis B Polio (3 types)

Documentation of disease confirmed for Varicella

Reviewed by _____ Date _____

Revised 12/15/2015