NASSAU COUNTY
EMERGENCY MEDICAL SERVICES ACADEMY

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EMS STUDENT IMMUNIZATION CERTIFICATION

To be completed by Physician or Health Care Facility Official—***ORIGINALS ONLY Permitted***—**DO NOT FAX**

Name:
Last First Middle Initial

Address:

City: State: Zip:

Date of Birth: Course Number:

PHYSICIAN/PROFESSIONAL HEALTH CARE PROVIDER CERTIFICATION

1. The undersigned does certify the person listed above does not have any health impairments that would be of potential risk to patients or personnel, or which might interfere with the performance of responsibilities as well as the following immunization record. ***All Lab Titers must be attached to this form.***

a)	**Measles**	**Titer Date:** ___/___/___	☐ IMMUNE	☐ Non-IMMUNE	☐ Equivocal
b)	**Mumps**	**Titer Date:** ___/___/___	☐ IMMUNE	☐ Non-IMMUNE	☐ Equivocal
c)	**Rubella**	**Titer Date:** ___/___/___	☐ IMMUNE	☐ Non-IMMUNE	☐ Equivocal
d)	**Varicella**	**Titer Date:** ___/___/___	☐ IMMUNE	☐ Non-IMMUNE	☐ Equivocal
e)	**Hepatitis B Surface Antibody**	**Titer Date:** ___/___/___	☐ IMMUNE	☐ Non-IMMUNE	☐ Equivocal

If any titer is non-immune or equivocal, the student is required to begin the immunization series.

Measles Immunization:	**#1 Date** ___/___/___	**#2 Date** ___/___/___	
Mumps Immunization:	**#1 Date** ___/___/___	**#2 Date** ___/___/___	
Rubella Immunization:	**#1 Date** ___/___/___		
Varicella Immunization:	**#1 Date** ___/___/___	**#2 Date** ___/___/___	
Hepatitis B Immunization:	**#1 Date** ___/___/___	**#2 Date** ___/___/___	**#3 Date** ___/___/___

2A. **PPD Tuberculin Skin Test:** Test Date: ___/___/___ _______ mm. induration

(If more than 10 mm. induration, please attach a copy of a subsequent chest x-ray and pulmonologist report.)

◆◆ ***(PPD testing must be completed annually, not longer than 1 year from course completion date.)***

—OR—

2B. **Quantiferon Gold or T Spot:** Test Date ___/___/___ Result: ☐ Positive ☐ Negative

3A. **Influenza Vaccine:** Date: ___/___/___ **attach proof**

3B. **COVID-19 Vaccine:** Date: ___/___/___ **attach proof**

PHYSICIAN OR HEALTH CARE FACILITY OFFICIAL (STAMP REQUIRED)

Name: ______________________ MD/RN/PA **ORIGINAL Signature**: ______________________

Title: ______________________ Date: ___/___/___ Phone: (____) ____-____

Facility Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Items 1 and 2A/2B are required by the New York State Department of Health for any person entering a hospital or health care facility for clinical observation (NYCRR Title 10, Section 405.3).

Nassau County EMS Academy

IMMUNIZATION REQUIREMENTS

All matriculated students must provide the following information with verification from the student's physician. New York State Law mandates that students not in compliance with the requirements 30 days after the start of classes are to be withdrawn from school and required to leave campus. No religious exemptions accepted for immunizations.

New York State Department of Health Requirements

Physical examination: History and physical examination performed within 12 months of appointment, of sufficient scope to confirm that there are not health impairments including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that would be of potential risk to patients or personnel, or which might interfere with the performance of responsibilities.

Measles (Rubeola)

- Serological evidence of immunity (titer) through a blood test performed by an approved medical laboratory, OR
- Statement from the diagnosing physician that the student has had measles disease.

Mumps

- Serological evidence of mumps immunity(titer) through a blood test performed by an approved medical laboratory, OR
- Statement from the diagnosing physician that the student has had mumps disease.

Rubella

- Serological evidence of rubella antibodies (titer) through a blood test performed by an approved medical laboratory.

Tuberculin Skin Test (PPD): **One** Mantoux intradermal skin tests (PPD) and interpretations is required, **within five months of the start of the class,** unless history of past positive skin test is reported. Tine tests are not acceptable. If a PPD is positive, a chest x-ray **report** since time of positive PPD result needs to be enclosed.

Hepatitis B: The Centers for Disease Control and Prevention strongly recommend vaccination with Hepatitis B Vaccine for health care professionals. Student must provide proof of immunization or signed declination.

Varicella: **Proof of history of chicken pox disease, verification by serologic screening or two vaccinations against Varicella.**

Other recommendations:

Meningococcus: **The CDC recommends that health providers who have direct patient contact should receive this vaccination.**

Tetanus/Diphtheria: **The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it.**

Influenza Vaccine: **Date__________ attach proof**

***COVID-19 Vaccine*: Date __________ attach proof**