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

Student's Name	Date of Birth __ __ / __ __ / __ __ __ __
OSIS #	ATS DBN

INSTRUCTIONS FOR THE REQUESTING MEDICAL PROVIDER

New York State Public Health Law §2164 allows for laboratory documentation of immunity to satisfy the immunization requirements for school/childcare attendance for measles, mumps, rubella, varicella, and hepatitis B. Serologic evidence of immunity to polio is acceptable only if results are positive for all three serotypes and testing was done prior to September 1, 2019. **Serologic results are not acceptable proof of immunity to diphtheria, tetanus or pertussis.** Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella (chicken pox) disease is acceptable proof of immunity to varicella only. Parent history of varicella disease is not acceptable.

As the child's medical provider, I certify that this child has (select all that apply):

Lab evidence of immunity*: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Hepatitis B ☐ Polio (3 serotypes)

Varicella disease history*: ☐ Varicella disease (documented)

* You must include one of the following documents for laboratory evidence of immunity or varicella documentation:

- A copy of the laboratory result including student name, DOB, test results and either reference range or qualitative result (e.g. positive, immune); you must sign the document and must specify which results indicate laboratory immunity (e.g., 'measles immune, rubella immune'). Equivocal results are not accepted as proof of immunity.
- A printout of the child's immunization history page from the Citywide Immunization Registry indicating that the child had provider-documented varicella disease.
- The original medical note confirming varicella disease.

I am the student's treating health care practitioner:

Physician Name:	**NYS License #** __ __ __ __ __ __
Physician Signature:	**Degree:** ☐ MD ☐ DO ☐ NP ☐ PA
Office Phone (__ __ __) __ __ __ - __ __ __ __ Ext __ __ __ __ **Cell Phone** (__ __ __) __ __ __ - __ __ __ __	**Stamp**
Date __ __ / __ __ / __ __ __ __	

PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

I, authorize _____ (**health professional**) to provide the New York City Departments of Health and Education with information contained in my child's medical record, including, but not limited to laboratory or other records supporting this request.

Parent/Guardian Name: _____

Parent/Guardian's signature _____ Date: _ _ /_ _ /_ _ _ _

NYC DOHMH USE ONLY

Confirmed immunity ☐ MEASLES	☐ MUMPS	☐ RUBELLA	☐ VARICELLA	☐ HEP B	☐ VARICELLA DISEASE	☐ POLIO

Reviewed by _____ Date __ __ / __ __ / __ __ __ __