STUDENT HEALTH CENTER REQUIREMENTS

One Gustave L. Levy Place
Box 1260
New York, NY 10029

Icahn School of Medicine at Mount Sinai

Phone: (212) 241-6023
Fax: (212) 241-8008
studenthealth@mssm.edu

All incoming students must complete the following mandatory Student Health requirements and return all forms to Student Health by **JULY 1. For Graduate school spring sessions, these requirements MUST be completed before the start of classes**.

Be sure to plan ahead as this process can take several months to complete. All forms in this packet should be submitted to Student Health by ***email*** to: studenthealth@mssm.edu

Student Health Center Checklist (All forms due July 1st):

- ☐ Student Health Form
- ☐ Meningococcal Vaccine Response
- ☐ Consent for Provider - Patient Communication
- ☐ Tuberculosis, Vaccination and Titers Response Form
- ☐ Copy of post immunization titer lab reports
- ☐ Physical Exam

Description of Requirements:

Student Health Form: All incoming students must fill out each section of this form.

Meningococcal Meningitis Vaccination Form: All incoming students must read and sign this form.

Consent for Patient Provider Communication: All incoming students must read and sign this form, if the student wishes to communicate with Student Health via e-mail.

Tuberculosis, Vaccination and Titers Response Form: All incoming students must complete part 1 of the Tuberculosis, Vaccination and Titers Form and have your healthcare provider fill out and sign part 2 of this form. Healthcare Providers must also attach lab results showing the post immunization titers. A tuberculosis screening test (either PPD or IGRA) is required for all incoming students.

If you have a history of a positive PPD or IGRA, Student Health a chest x-ray within 1 year of school's start.

Physical Exam: All incoming students must have a physical exam. Students must complete part 1 of the Physical Exam Form and have their doctor fill out and sign part 2 of this form.

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FREQUENTLY ASKED QUESTIONS

Q: Why isn't my immunization history sufficient for proof of immunity?
A: Icahn School of Medicine at Mount Sinai adheres to the guidelines of the American Association of Medical Colleges (AAMC) and the Center for Disease Control (CDC) and Prevention for healthcare workers. Proof of immunity must be verified via blood titers for Measles, Mumps, Rubella, Varicella and Hepatitis B. Immunity for Tetanus and Pertussis are verifiable by a recent dose of Diphtheria Tetanus Acellular Pertussis (TDAP) vaccine received in the past 10 years.

Q: If I need blood titers, why should I submit my immunization history?
A: Immunization dates are important in the event that your blood titers are negative. Each required titer has a specific number of doses needed to complete a series. For example, New York State requires the following: Either two doses of MMR, *or* two doses of Measles, one dose of Mumps and one dose of Rubella. If a titer is negative for any of the required immunizations, specific CDC guidelines are available for attempting to boost one's immunity. In most cases, an additional dose of the vaccine will be administered and the titer rechecked after 30 days, if it is not medically contraindicated.

Q: If any of the Immunization titers are Negative, Equivocal or Inconclusive, what will I need to do?
A*:*
1. *Measles, Mumps and Rubella – An additional MMR vaccine booster will be required.*
2. *Varicella – An additional varicella vaccine booster will be required.*
3. *Hepatitis B – Initiating the3 dose series booster may be required.*

Q: What if I had the Varicella infection (chickenpox) as a child?
A: In most cases, your titer will prove immunity if you had the infection in the past. Otherwise you will be required to complete a 2 dose series for Varicella.

Q: I started the Hepatitis B series but never completed it. Do I need to start the series over?
A: Generally, we don't restart the series. The most common approach would be to give the missing remaining doses in Student Health, wait 30 days and then get a Hepatitis B Surface Antibody drawn.

Q: I had a PPD (TB skin test) last year. Do I need another one?
A: A TB screening within 1 year of your enrollment date is required. A PPD/TB screening will then be required annually for all medical students.

Q: What if I have had a positive PPD in the past?
A: You must attach a copy of a chest x-ray report dated within 1 year of your enrollment with your immunization record. Please note that receiving the BCG vaccine does not always present a positive reaction. Therefore, a chest x-ray is required for positive PPD reaction (greater than 10mm).

Q: Why does the Icahn School of Medicine at Mount Sinai require so much proof of immunization?
A: All medical colleges require the same. It is our intent to maintain healthcare and provide knowledge of communicable diseases within the profession you have chosen. It is important in healthcare to *KNOW YOUR STATUS.*

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STUDENT HEALTH FORM

STUDENT INFORMATION

Student Name (First, Middle Initial , Last)

Program Entering (please check one)
☐ MD ☐ MD/PhD ☐ PhD ☐ MPH ☐ MSBS ☐ PREP
☐ Clinical Research ☐ Genetic Counseling ☐ Other _____

Local Address | **City** | **State** | **Zip**

Telephone Number
☐ HOME ☐ CELL

Email

Birthplace

Gender
☐ Male ☐ Female

Gender Identity
☐ Male ☐ Female ☐ Other _____

Gender Pronoun
☐ He ☐ She ☐ They ☐ Name Only ☐ Other_____

Current or Previous Mount Sinai Employee or Student
☐ Yes ☐ No

Marital Status
☐ Single ☐ Married

Date of Birth
_____ / _____ / _____

EMERGENCY CONTACT INFORMATION

Name

Relationship

Address | **City** | **State** | **Zip**

Telephone Number
☐ HOME ☐ CELL

PRIMARY CARE INFORMATION

Primary Care Provider

Address | **City** | **State** | **Zip**

Telephone Number

Specialists (name and phone)

MEDICAL HISTORY

FAMILY HISTORY

Check all that apply — Family member with disease

☐ Asthma _____

☐ Tuberculosis _____

☐ Diabetes _____

☐ Heart Disease _____

☐ Hypertension _____

☐ Kidney Disease _____

☐ Cancer, type _____

☐ Rheumatologic Disease, type _____

☐ Other, describe _____

Updated 01/5/17

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MEDICAL HISTORY, CONTINUED

PERSONAL HISTORY

(check all that apply)

- ☐ Sinus Infections
- ☐ Ear Infections
- ☐ Eye Problems
- ☐ Recurrent Colds
- ☐ Asthma
- ☐ Allergies
- ☐ Chronic Cough
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Tuberculosis or Positive PPD
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Chronic Diarrhea
- ☐ Constipation
- ☐ Peptic Ulcer
- ☐ Celiac Disease
- ☐ Urinary Tract Infections
- ☐ Kidney Disease
- ☐ Head Injury
- ☐ Headaches
- ☐ Dizziness / Fainting
- ☐ Seizures
- ☐ Paralysis
- ☐ Hearing Problems
- ☐ Speech Problems
- ☐ Joint Pain
- ☐ Gout
- ☐ Back Pain
- ☐ Anemia
- ☐ Sickle Trait / Disease
- ☐ Thalassemia Trait / Disease
- ☐ Weight Gain / Loss
- ☐ Insomnia
- ☐ Anxiety
- ☐ Depression
- ☐ Irregular menses
- ☐ Severe Cramps
- ☐ Breast Mass
- ☐ Other: _____

ADDITIONAL INFORMATION

Please answer the following questions:

Has your education or work been interrupted due to a medical reason in the past two years? _____

Medications (include over-the-counter drugs, vitamins, alternative medicines, insulin and contraceptive) Specify dosage: _____

Hospitalizations and surgeries (include year and reason): _____

Allergies (include medication, food and environmental allergens): _____

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MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter complete the following:

Check one box and sign below

I have:

☐ had the meningococcal meningitis immunization (Menactra™) within the past 5 years. Date received: _____

☐ read, or have had explained to me, the information regarding meningococcal meningitis. I will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider, *Student Health, or other health facility.

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____

Print Name: _____ Date of Birth: _____

Mailing Address: _____

Telephone Number: _____ Email Address: _____

* The SHC health provider will write a prescription for the vaccine. If you have the Student Health Insurance, you can fill it at the MSH pharmacy for $20. If not, the cost will depend on your prescription insurance.

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CONSENT FOR PROVIDER - PATIENT COMMUNICATION

I, _____, hereby consent to have Student Health staff communicate with me or members of their staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: test results, prescriptions, appointments, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mails communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of their office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

GENERAL CONSENT TO TREATMENT

By signing below, I, _____, authorize the staff of the Student Health Center to conduct diagnostic examinations, tests, administer vaccines and to provide any medications, treatment or therapy necessary to maintain my health. I understand that the health care provider will explain to me the reasons for any particular test or procedure, the available treatment options as well as alternative treatment.

I have been given information regarding HIV testing, and the HIV virus, how my HIV related information will be kept confidential and what laws protect people with HIV-AIDS from discrimination. I understand that the results will be documented in my medical records.

Consent for HIV related testing remains in effect until I revoke it. I may revoke my consent orally or in writing at any time. As long as this consent is in force, the staff at the Student Health Center may conduct additional tests without asking me to sign another consent form. The provider will notify me if other HIV tests will be performed.

Signature: _____ Date: _____

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TUBERCULOSIS, VACCINATION AND TITERS RESPONSE FORM

PART I: TO BE FILLED OUT BY STUDENT
STUDENT INFORMATION

Student Name (First, Middle Initial , Last)	**Date of Birth** ___/___/____	**Telephone Number** ☐ HOME ☐ CELL		
Address	**City**	**State**	**Zip**	**Email**

Gender ☐ Male ☐ Female	**Gender Identity** ☐ Male ☐ Female ☐ Other _____	**Gender Pronoun** ☐ He ☐ She ☐ They ☐ Name Only ☐ Other_____

PART II: TO BE FILLED OUT BY PROVIDER
SCREENING FOR TUBERCULOSIS

Date PPD Planted: _____ ☐ History of BCG Vaccine
(must be within 6 months)

Date PPD Read: _____ Result: _____mm

Interpretation: Positive [ ] Negative [ ]

OR

Quantiferon Gold TB test Date: _____ Result: _____(***please provide copy***)

(must be within 6 months)

If Previously Positive:

Chest X-ray Date: _____ Result: _____(***please provide copy***)
(must be within 1 year)

VACCINATION AND TITERS HISTORY

THE FOLLOWING VACCINES AND LABORATORY TESTS ARE MANDATORY. PLEASE ATTACH THE POST IMMUNIZATION LAB RESULTS SHOWING:

	MMR	**Varicella**	**Hepatitis B**	**Tdap**
Dates	1. 2. **AND**	1. 2. **AND**	1. 2. 3. **AND**	**Must be within 10 yrs.** 1.
Titer (date/result) **complete & attach lab report results showing immunity**	Measles IgG Mumps IgG Rubella IgG	Varicella IgG	Hep B Surface Ab (QUANTITATIVE preferred)	No titers required

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OPTIONAL (HIGHLY RECOMMENDED) VACCINES

The following vaccines are recommended. Please indicate vaccination date(s).

1. Hepatitis A Date(s): _____ _____
2. IPV Date(s): _____
3. HPV Date(s): _____ _____ _____
4. FLU (if attending between October - May) : _____

Please also send us any other vaccines you have received for travel.

1. Vaccine: _____ Date(s): _____
2. Vaccine: _____ Date(s): _____
3. Vaccine: _____ Date(s): _____

PROVIDER SIGNATURE AND INFORMATION

Provider Signature: _____ **Date:** _____

Provider Stamp:

Name:
Address:
Telephone number:
Email:

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PHYSICAL EXAM FORM

PART I: TO BE FILLED OUT BY STUDENT
PATIENT INFORMATION

Student Name (First, Middle Initial, Last)

Program (please check one)
☐ MD ☐ MD/PhD ☐ PhD ☐ MPH ☐ MSBS ☐ PREP
☐ Clinical Research ☐ Genetic Counseling ☐ other _____

Date of Birth
____ / ____ / ____

Gender
☐ Male ☐ Female

Gender Identity
☐ Male ☐ Female ☐ Other:_____

Gender Pronoun
☐ He ☐ She ☐ They ☐ Name Only ☐ Other____

Phone
☐ HOME ☐ CELL

Email

☐ ENTRY PHYSICAL EXAM
☐ 2nd YEAR EXAM

PART II: TO BE FILLED OUT BY PROVIDER
STUDENT HISTORY

DATE OF EXAM: _____/_____/ _____

MEDICAL HISTORY

PMH: _____

PSH: _____

Hospitalizations: _____

Mental Health: _____

FHx: _____

Meds: _____

_____

Allergies: _____

GYN: _____ Last Pap: _____ LMP: _____

SOCIAL HISTORY

Smoking _____ Sleep Habits _____

Alcohol _____ Helmets / Seat Belts _____

Recreational Drugs _____ Dental _____

Exercise _____ Sexual History _____

Nutrition _____ Other _____

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PHYSICAL EXAM

Vital Signs: **Ht:** _____ **Wt:** _____ **BMI:** _____ **BP:** _____ **Pulse:** _____

HEENT
Ears_____
EOMI_____
PERRL_____
Fundi_____
Sclera_____
Nose_____
OroPharynx_____

NECK
Supple_____
Thyroid_____
Lymph Nodes_____
Masses_____

CHEST
Breast_____
Nipples _____
Lungs_____
Heart_____

ABDOMEN
Soft_____
Bowel Sounds_____
Palpation_____
Liver/Spleen_____

GENITOURITAL
Testes_____
Hernia_____
Prostate_____
Ano-Rectal_____
PAP (date)_____
GYN_____

MUSCULOSKLETAL
Spine_____
Joints_____
Extremities_____
Pulses_____

DERM
Skin_____
Scars_____
Hair_____
Nails_____

NEURO
CN_____
Motor_____
Sensory_____
Reflexes_____
Cerebellar_____

OTHER
_____
_____
_____
_____

Assessment: _____
_____
_____

Plan: _____
_____
_____

Vaccine Given: MMR_____ Varicella_____ Hep B_____ Hep A_____ HPV_____ Other_____

Labs: CBC _____ BMP _____ Cholesterol_____ Other _____

_____ Print Name

_____ License #

_____ State

_____ Signature

_____ Address

Updated 01/5/17