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.
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 the 3 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.
# Student Health Form

## Student Information

<table>
<thead>
<tr>
<th>Student Name (First, Middle Initial, Last)</th>
<th>Program Entering (please check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ MD □ MD/PhD □ PhD □ MPH □ MSBS □ PREP</td>
</tr>
<tr>
<td></td>
<td>□ Clinical Research □ Genetic Counseling □ Other _______</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Local Address</th>
<th>Telephone Number</th>
<th>Email</th>
<th>Birthplace</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>□ HOME □ CELL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Gender Identity</th>
<th>Gender Pronoun</th>
<th>Marital Status</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Male</td>
<td>□ Male □ Female □ Other _______</td>
<td>□ He □ She □ They □ Name Only □ Other _______</td>
<td>□ Single □ Married</td>
<td><strong>/</strong>/____</td>
</tr>
</tbody>
</table>

## Emergency Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
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<th>State</th>
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</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>HOME</th>
<th>CELL</th>
</tr>
</thead>
</table>

## Primary Care Information

<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>HOME</th>
<th>CELL</th>
</tr>
</thead>
</table>

| Specialists (name and phone) | |
|-------------------------------| |

## Medical History

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Asthma</td>
<td>Family member with disease</td>
</tr>
</tbody>
</table>

| □ Tuberculosis       | |
| □ Diabetes           | |
| □ Heart Disease      | |
| □ Hypertension       | |
| □ Kidney Disease     | |
| □ Cancer, type       | |
| □ Rheumatologic Disease, type | |
| □ Other, describe    | |
### 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 | ☐ | 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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Student Health Form  
Page 2 of 2
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.
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: ________________________
# Tuberculosis, Vaccination and Titer Response Form

## Part I: To be Filled Out By Student

**Student Information**

<table>
<thead>
<tr>
<th>Student Name (First, Middle Initial, Last)</th>
<th>Date of Birth</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>/</strong>/____</td>
<td>HOME/CELL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Email</th>
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</table>

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<thead>
<tr>
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<th>Gender Pronoun</th>
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<td>He</td>
</tr>
<tr>
<td>Female</td>
<td>Female</td>
<td>She</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>They</td>
</tr>
<tr>
<td></td>
<td>Name Only</td>
<td></td>
</tr>
</tbody>
</table>

## Part II: To be Filled Out By Provider

**Screening for Tuberculosis**

Date PPD Planted: ____________________________  □ History of BCG Vaccine

(Date must be within 6 months)

Date PPD Read: ____________________________ Result: __________ mm

Interpretation: Positive [ ]  Negative [ ]

OR

Quantiferon Gold TB test Date: ________________ Result: __________ (please provide copy)  

(Date must be within 6 months)

If Previously Positive:

Chest X-ray Date: ____________________________ Result: __________ (please provide copy)  

(Date must be within 1 year)

**Vaccination and Titer History**

The following vaccines and laboratory tests are mandatory. Please attach the post immunization lab results showing:

<table>
<thead>
<tr>
<th>MMR</th>
<th>Varicella</th>
<th>Hepatitis B</th>
<th>Tdap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>2.</td>
<td>1.</td>
</tr>
</tbody>
</table>

AND

Measles IgG

Varicella IgG

Hep B Surface Ab (QUANTITATIVE preferred)

AND

Mumps IgG

Rubella IgG

AND

No titers required

Must be within 10 yrs.

Updated 01/5/17
# 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:  

Tuberculosis, Vaccination and Titers Response Form  
Page 2 of 2
**PHYSICAL EXAM FORM**

**PART I: TO BE FILLED OUT BY STUDENT**

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Student Name (First, Middle Initial, Last)</th>
<th>Program (please check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MD</td>
</tr>
<tr>
<td></td>
<td>Clinical Research</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Gender</th>
<th>Gender Identity</th>
<th>Gender Pronoun</th>
</tr>
</thead>
<tbody>
<tr>
<td>____ / ____ / ____</td>
<td>Male</td>
<td>Female</td>
<td>Other:______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME</td>
<td>CELL</td>
</tr>
</tbody>
</table>

**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 __________________________
## PHYSICAL EXAM

### Vital Signs:
- Ht: ______
- Wt: ______
- BMI: ______
- BP: ______
- Pulse: ______

### HEENT
- Ears: ______
- EOMI: ______
- PERRL: ______
- Fundi: ______
- Sclera: ______
- Nose: ______
- OroPharynx: ______

### ABDOMEN
- Soft: ______
- Bowel Sounds: ______
- Palpation: ______
- Liver/Spleen: ______

### DERM
- Skin: ______
- Scars: ______
- Hair: ______
- Nails: ______

### GENITOURITAL
- Testes: ______
- Hernia: ______
- Prostate: ______
- Ano-Rectal: ______
- PAP (date): ______
- GYN: ______

### NEURO
- CN: ______
- Motor: ______
- Sensory: ______
- Reflexes: ______
- Cerebellar: ______

### OTHER
- ______
- ______
- ______

### CHEST
- Breast: ______
- Nipples: ______
- Lungs: ______
- Heart: ______

### MUSCULOSKLETAL
- Spine: ______
- Joints: ______
- Extremities: ______
- Pulses: ______

### NECK
- Supple: ______
- Thyroid: ______
- Lymph Nodes: ______
- Masses: ______

### ABOMEN
- Soft: ______
- Bowel Sounds: ______
- Palpation: ______
- Liver/Spleen: ______

### CHEST
- Breast: ______
- Nipples: ______
- Lungs: ______
- Heart: ______

### MUSCULOSKLETAL
- Spine: ______
- Joints: ______
- Extremities: ______
- Pulses: ______

### DERM
- Skin: ______
- Scars: ______
- Hair: ______
- Nails: ______

### GENITOURITAL
- Testes: ______
- Hernia: ______
- Prostate: ______
- Ano-Rectal: ______
- PAP (date): ______
- GYN: ______

### NEURO
- CN: ______
- Motor: ______
- Sensory: ______
- Reflexes: ______
- Cerebellar: ______

### OTHER
- ______
- ______
- ______

### Assessment:


### Plan:


### Vaccine Given:
- MMR: ______
- Hep B: ______
- HPV: ______
- Varicella: ______
- Hep A: ______
- Other: ______

### Labs:
- CBC: ______
- BMP: ______
- Cholesterol: ______
- Other: ______

---

**Print Name**

**License #**

**State**

**Signature**

**Address**

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**PHYSICAL EXAM FORM**

**PAGE 2 OF 2**

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Updated 01/5/17