Icahn School of Medicine at Mount Sinai

Student Health Center
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574
Telephone: (212) 241-6023
E-mail: studenthealth@mssm.edu

Student Health Form

Section A: To Be Completed By Student			
Name (First, Middle, Last)	**Date of Birth (MM/DD/YY)**	**Telephone**	**E-mail address**
Preferred Gender Pronoun	**Sex at Birth**	**Gender Identity**	**Program accepted into:**

Section B: To Be Completed By Provider	
Allergies and reactions	
Past medical history	
Past surgical history	
Hospitalizations	
Mental health	
Medications and dosages	
Family history	

PHYSICAL EXAM

BP: _____ HR: _____ WT: _____ HT: _____

	Normal	Significant findings
General	☐	
HEENT	☐	
Heart	☐	
Lungs	☐	
Abdomen	☐	
Back	☐	
Extremities	☐	
Skin	☐	
Neurologic	☐	
If applicable, date of last cervical PAP smear	☐	

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IMMUNIZATIONS

Required Immunizations:

- Measles (Rubeola), Mumps and Rubella (MMR) *(Vaccinations Dates **OR** Positive Titer)*
- Varicella *(Vaccinations Dates **OR** Positive Titer)*
- Hepatitis B *(Vaccination Dates **AND** Positive Titer)*
- COVID-19 *(Vaccination Dates only)*
- Tdap *(Vaccination Date only)*

Recommended Immunizations:

- Influenza
- Hepatitis A
- Polio
- Meningococcal
- Human Papillomavirus (HPV)

Please attach Lab Reports for Titer Results. Lab reports MUST include full name, date of birth, lab result and reference ranges.

REQUIRED IMMUNIZATIONS

Measles (Rubeola), Mumps & Rubella (MMR)

Option 1: Two doses of MMR vaccine after first birthday, at least one month apart

	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)
MMR	#1	#2

***OR* Option 2:** Two doses of measles vaccine, two doses of mumps vaccine, and one dose of rubella vaccine

Measles	#1	#2
Mumps	#1	#2
Rubella	#1	

***OR* Option 3:** Positive titers (IgG) showing immunity to measles, mumps and rubella.

MUST ATTACH LAB REPORTS

	Date	Serology Result
Measles IgG		☐ Reactive ☐ Not reactive
Mumps IgG		☐ Reactive ☐ Not reactive
Rubella IgG		☐ Reactive ☐ Not reactive

Varicella

Option 1: Two doses of Varicella vaccine after first birthday, at least one month apart

Date #1	Date #2

***OR* Option 2:** Positive titers (IgG) showing immunity to varicella

MUST ATTACH LAB REPORTS

	Date	Serology Result
Varicella IgG		☐ Reactive ☐ Not reactive

Hepatitis B

Three doses of Hepatitis B vaccine

Date #1	Date #2	Date #3

***AND** Positive Hepatitis B surface IgG antibody titer at least 30 days after last dose (quantitative result preferred)*

MUST ATTACH LAB REPORTS

	Date	Serology Result
Hepatitis B Surface Antibody (IgG)		

Hepatitis B boosters
***MUST** initiate Hepatitis B boosters if antibody titer is not reactive*

Booster #1	Booster #2	Booster #3
Date: _____	Date: _____	Date: _____
☐ Energix-B	☐ Energix-B	☐ Energix-B
☐ Heplisav-B	☐ Heplisav-B	☐ Heplisav-B

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REQUIRED IMMUNIZATIONS (continued)

COVID-19

All ISMMS students must be **fully vaccinated** with a COVID-19 vaccine that is authorized/approved by the US Food and Drug Administration or the World Health Organization. A **booster dose** is required for all eligible students. Matriculating students who are not yet eligible for a booster may provisionally enroll pending receipt of a booster within 2 weeks of eligibility.

Fully Vaccinated (as of March 2022):

- At least 14 days post second dose of the Pfizer, Moderna or an equivalent WHO-EUL vaccine series
- At least 14-days post one dose of the Johnson & Johnson COVID-19 vaccine

Booster Eligibility

Five months after completing the Pfizer, Moderna or equivalent WHO-EUL vaccine series, or two months after an initial J&J vaccine.

	Manufacturer	**Date**	
Dose 1			**MUST ATTACH COVID VACCINE CARD**
Dose 2			
Dose 3 (if applicable)			
Dose 4 (if applicable)			

Tdap One dose of TDAP vaccine within the past 10 years	**Date** (MM/DD/YYYY)	

RECOMMENDED IMMUNIZATIONS

Influenza *Matriculated students must receive annually on/after August roll out*				
Hepatitis A	#1	#2		
Polio	#1	#2	#3	
Human Papillomavirus (HPV)	#1	#2	#3	
Meningococcal Select booster brand ☐ Menactra ☐ Menveo	#1			

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TUBERCULOSIS SCREENING			
History of positive test **Yes** ☐ **No** ☐ If **yes**, complete section A. If **no**, complete section B.			
A: History of positive TB test			
MUST ATTACH LAB and X-Ray Reports	**Date of Positive Test**	**IGRA or PPD** (if PPD, include mm)	**Date of CXR and Read**
	Treatment History Did you receive treatment for Latent or active TB? Yes ☐ No ☐		
	Medication(s) Taken:		
	Dates Started / Completed:		

B: NO history of positive TB test

Please complete one of following **within 6 months of program start date**:

Test Type	**Date**	**Result / Interpretation**
IGRA (Quantiferon or T-spot) **MUST ATTACH LAB REPORTS**		☐ Positive ☐ Negative
PPD	**Plant _____ / Read_____**	☐ Positive ☐ Negative If positive: _____ mm

PROVIDER'S SIGNATURE			
Provider's name, title and license number:	**Provider's signature:**	**Office Stamp**	**Today's Date (MM/DD/YYYY):**

REMINDER: Please SUBMIT all required lab reports

- **Hepatitis B surface antibody (Hep Bs AB)**
- **MMR antibody (IgG) (if applicable)**
- **Varicella antibody (IgG) (if applicable)**
- **Quantiferon gold (if applicable)**
- **Chest x-ray, if history of positive PPD or Quantiferon gold**