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
Program accepted into	Sex at Birth	Gender Identity	Preferred Gender Pronoun

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)*
- Influenza (*Vaccination Date only)*

Strongly Recommended Immunization:

- Polio - Due to increased polio activity in NYS, we strongly encourage all students to ensure that they are polio immune. If you have not been vaccinated against polio and are interested in getting vaccinated on arrival please contact the Student Health Center.

Recommended Immunizations:

- Hepatitis A
- 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)

		Date (MM/DD/YYYY)	Date (MM/DD/YYYY)
Option 1: Two doses of MMR vaccine after first birthday, at least one month apart	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

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

	Date	Date	Date
Three doses of Hepatitis B vaccine	#1	#2	#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)	
Influenza One dose, in line with seasonal availability (given in/after August in the Northern Hemisphere)	**Date** (MM/DD/YYYY)	

STRONGLY RECOMMENDED IMMUNIZATIONS

Polio	#1	#2	#3	

RECOMMENDED IMMUNIZATIONS

Hepatitis A	#1	#2		
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**