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) – Required for Spring matriculants only*

Recommended Immunizations:

- Hepatitis A
- Human Papillomavirus (HPV)
- Meningococcal
- Polio - If you have not been vaccinated against polio and are interested in getting vaccinated on arrival please contact the Student Health Center.

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 ☐ Non-reactive
Mumps IgG		☐ Reactive ☐ Non-reactive
Rubella IgG		☐ Reactive ☐ Non-reactive

If result is "Non-Reactive", MMR Booster must be initiated

MMR Booster Date: _____

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 ☐ Non-reactive

If result is "Non-Reactive", Varicella Booster must be initiated

Varicella Booster Date: _____

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)		**Quantitative Test** MIU/ml **OR Qualitative Test** ☐ Reactive ☐ Non-reactive

If result is "Not Reactive" or <9.9 MIU/ml, Hep B Boosters must be initiated (enter below)

Hepatitis B boosters
***MUST** initiate Hepatitis B boosters if antibody titer result is "Not reactive" or <9.9 MIU/ml*

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

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REQUIRED IMMUNIZATIONS (continued)

COVID-19

All students must demonstrate proof of vaccination against COVID-19. Either of the following options will be accepted:

Option 1: At least **one dose** of Moderna or Pfizer-BioNTech **updated mRNA vaccine** (given in/after August in the Northern Hemisphere *preferred*)

Option 2: **A primary series** of any US FDA or WHO approved COVID-19 vaccine **+** at least **one booster dose**

Received Updated / Seasonal mRNA vaccine? ☐ **Yes** ☐ **No**

*If **Yes**, complete details below, **and** document any additional doses in the "Other COVID vaccine doses" section*
*If **No**, document a **primary series** of any US FDA or WHO approved COVID-19 vaccine **+ at least one booster dose** in the "Other COVID vaccine doses" section*

MUST ATTACH COVID VACCINE CARD

Updated / Seasonal mRNA Vaccine			**Other COVID vaccine doses**		
	Manufacturer	**Date**		**Manufacturer**	**Date**
Seasonal Dose (given in/after August in the Northern Hemisphere; *preferred*)			**Dose 1**		
			Dose 2		
			Dose 3		
			Dose 4		
Tdap One dose of TDAP vaccine within the past 10 years			**Date** (MM/DD/YYYY)		
Influenza (*Required for Spring matriculants only*) One dose, in line with seasonal availability (given in/after August in the Northern Hemisphere)			**Date** (MM/DD/YYYY)		

RECOMMENDED IMMUNIZATIONS

Hepatitis A	#1	#2		
Human Papillomavirus (HPV)	#1	#2	#3	
Meningococcal Select booster brand	☐ **Menactra Date: _____** **or** ☐ **Menveo Date: _____**			
Polio	#1	#2	#3	#4

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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

Positive Test *(Must attach lab report)*	**Chest X-Ray** *(Must attach report)*
Date:_____	Date:_____
Test Type (circle one): ☐ IGRA ☐ PPD _____ mm	Results: _____

Treatment History
Did you receive treatment for Latent or active TB? ☐ Yes ☐ No
Medication(s) Taken: _____
Dates Started / Completed: _____

Last TB symptom and risk questionnaire (*must be completed within 1 year of start date*):
Date:___/___/_____ Results: ☐ Negative ☐ Positive (if positive, please provide updated CXR and result)

B: NO history of positive TB test

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

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**