

STUDENT HEALTH CENTER REQUIREMENTS

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All incoming students must complete the following mandatory Student Health requirements and return all forms to Student Health by **JULY 1**.

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 and Treatment
- Tuberculosis, Vaccination and Titers Response Form
- 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 and Treatment: All incoming students must read and sign this form, if the student wishes to receive treatment at Student Health and 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. The PPD test is required for all students and is required annually.

If you have a history of a positive PPD or Quantiferon Gold TB test, Student Health requires a chest x-ray within 6 months 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 Centers for Disease Control and Prevention (CDC) for healthcare workers, which state that proof of immunity must be verified via blood titers for Measles, Mumps, Rubella, Varicella and Hepatitis B.

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 – Two doses of Varicella vaccine given at least 30 days apart.*
3. *Hepatitis B – 4th Hepatitis B will 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 6 months 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 acceptable for positive PPD reaction (greater than 10mm). We will also accept a Quantiferon Gold test result completed within 1 year of enrollment.

Q: Why does the Icahn School of Medicine at Mount Sinai require so much proof of immunization?

A: All medical schools have similar requirements. It is our intent to promote health and wellness among our students and patients and to 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			
Student Name (First, Middle Initial, Last)		Program <input type="checkbox"/> MD <input type="checkbox"/> MD/PhD <input type="checkbox"/> PhD <input type="checkbox"/> MPH <input type="checkbox"/> MSBS <input type="checkbox"/> PREP <input type="checkbox"/> Clinical Research <input type="checkbox"/> Genetic Counseling	
Local Address	City	State	Zip
Telephone Number <input type="checkbox"/> HOME <input type="checkbox"/> CELL	Email		
Birthplace	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			
EMERGENCY CONTACT INFORMATION			
Name		Relationship	
Address	City	State	Zip
Telephone Number <input type="checkbox"/> HOME <input type="checkbox"/> 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	
<input type="checkbox"/> Tuberculosis _____			
<input type="checkbox"/> Diabetes _____			
<input type="checkbox"/> Heart Disease _____			
<input type="checkbox"/> Hypertension _____			
<input type="checkbox"/> Kidney Disease _____			
<input type="checkbox"/> Cancer, type _____			
<input type="checkbox"/> Rheumatologic Disease, type _____			
<input type="checkbox"/> Other, describe _____			

MEDICAL HISTORY, CONTINUED

PERSONAL HISTORY

(check all that apply)

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

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 to be filled at the MSH pharmacy for \$20

CONSENT FOR PROVIDER - PATIENT COMMUNICATION

I, _____, hereby consent to have Student Health staff communicate with me or members of her 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 her 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, that testing is voluntary and can be done anonymously, 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.

I do not want an HIV test

Signature: _____

Date: _____

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 ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City	State	Zip
Telephone Number <input type="checkbox"/> HOME <input type="checkbox"/> CELL	Email		

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

Date PPD Planted: _____
(must be within 1 year)

Date PPD Read: _____ Result: _____ mm

Interpretation: Positive [] Negative []

OR

Quantiferon Gold TB test Date: _____ Result: _____ *(please provide copy)*
(must be within 1 year)

If Previously Positive:

Chest X-ray Date: _____ Result: _____ *(please provide copy)*
(must be within 6 months)

VACCINATION AND TITERS HISTORY

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

	MMR	Varicella	Hepatitis B	Tdap
Dates	1. 2.	1. 2.	1. 2. 3.	1.
	AND	OR	AND	
Titer (date/result) <i>(complete & attach results showing immunity)</i>	Measles IgG Mumps IgG Rubella IgG	Varicella IgG	Hep B Surface Ab	No titers required

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): _____

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 #:
Email:

PHYSICAL EXAM FORM

PART I: TO BE FILLED OUT BY STUDENT PATIENT INFORMATION

Student Name		Program <input type="checkbox"/> MD <input type="checkbox"/> MD/PhD <input type="checkbox"/> PhD <input type="checkbox"/> MPH <input type="checkbox"/> MSBS <input type="checkbox"/> PREP <input type="checkbox"/> Clinical Research <input type="checkbox"/> Genetic Counseling	
Date of Birth ____ / ____ / ____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone <input type="checkbox"/> HOME <input type="checkbox"/> CELL	Email		<input type="checkbox"/> ENTRY PHYSICAL EXAM

PART II: TO BE FILLED OUT BY PROVIDER STUDENT HISTORY

Date of Exam: ____ / ____ / ____

MEDICAL HISTORY

PMH: _____

PSH: _____

Hospitalizations: _____

FHx: _____

Meds: _____

Allergies: _____

GYN: _____ Last Pap: _____ LMP: _____

SOCIAL HISTORY

Smoking _____	Sleep Habits _____
Alcohol _____	Helmets / Seat Belts _____
Recreational Drugs _____	Dental _____
Exercise _____	Sexual History _____
Nutrition _____	Other _____

