Weill Cornell Medicine
Student Health Services

**Incoming Student Health, Immunization and TB screening Requirements**

Dear Student:

Congratulations on being accepted into one of the degree or certificate programs at Weill Cornell Medicine!

Weill Cornell Medicine Student Health Services (SHS) is committed to providing accessible, compassionate, cost-effective and high-quality health care and education that meets the unique primary health care needs of students, enhances your personal growth and development and supports other University goals and objectives. Our vision is to serve as your medical home during the time you are a student and to be your primary resource for occupational health, preventive medicine and primary care.

For students who pay the annual student health fee, SHS offers an array of primary care, occupational medicine and preventive health services including physical examinations, chronic disease management, treatment of acute illness, routine gynecologic care and contraceptive management, immunizations and management of body fluid exposures. A physician is also on call by phone during off-hours for health emergencies. Our nurse administrator oversees our immunization program and compliance with state and institutional guidelines. The student mental health and counseling services are available to provide you with high quality and confidential mental health services. We treat your health information with the utmost respect for your privacy and confidentiality as required by law.

Please review these pre-registration materials as there are a number of requirements you must meet before you can attend classes, work in a lab or be around patients. We strongly encourage you to meet these requirements with your current health care provider to avoid any delay in registration and initiation of coursework.

We look forward to a healthy and productive partnership.

Sincerely,
**Edgar Figueroa, M.D., M.P.H.**
Director of Student Health
Weill Cornell Medicine

Mail: 1300 York Avenue Box 258, New York, NY 10065 | T. 646.962.6942 | F. 646.962.1491

**Important Information**

**Document Submission Deadline**

| | |
|---|---|
| **Summer 2018 (start on/around 7/1):** | **6/1/2018** |
| **Fall 2018 (start on/around 8/20):** | **7/20/2018** |
| **Spring 2019 (start on/around 3/1):** | **2/1/2019** |

**Contact Information**

**For general questions: (646) 962-6942 or shs@med.cornell.edu**
**SHS Website: shs.med.cornell.edu**

**For submission of preregistration requirements:**

**USPS Address: Student Health Services, 1300 York Ave Box 258, New York, NY 10065**

**KEEP A COPY/SCAN OF ALL DOCUMENTS SUBMITTED IN EVENT THERE IS AN ISSUE WITH THE MAIL**

**Do NOT fax or email documents**

## New Student Pre-Registration Requirements

☐ **Patient Registration Form** - allows us to create your chart in our electronic medical record (1 page)

☐ **Health History** – complete the medical and mental health history questionnaire (4 pages)

☐ **Physical Exam** – provide documentation of a physical examination performed by a physician, nurse practitioner or physician assistant unrelated to you performed within the 12 months prior to your start date. Documentation of a completed physical exam from an electronic medical record is acceptable otherwise, have the form available in this packet completed and stamped by your health care provider. (1 page)

☐ **Meningococcal Meningitis Response Form** – Read the enclosed information regarding meningococcal disease and review and complete the meningococcal vaccine waiver. (1 page)

☐ **Immunization Form** - Have the form in this packet completed and signed/stamped by your health care provider. (3 pages + attachments)

- ☐ **Section 1: Measles (Rubeola), Mumps, Rubella (MMR)**

- 2 doses of MMR vaccine administered at least 28 days apart with the first dose being after your 1st birthday **OR**
- Two doses of measles, two doses of mumps and one dose of rubella **OR**
- Serologic proof of immunity (*preferred*)

☐ **Varicella**
- 2 doses of varicella vaccine administered at least 28 days apart after your 1st birthday **OR**
- Serologic proof of immunity (*preferred*). History of disease is not sufficient documentation.

☐ **Section 2: Hepatitis B** – documentation of three doses of vaccination AND post-vaccination measurement of Hepatitis B surface antibody

If post-vaccination antibody is non-reactive or equivocal, a Hepatitis B surface antigen test is required. If this is negative, you must receive a fourth dose of Hepatitis B vaccine. If you have already received two courses of hepatitis B vaccine (6 doses), provide dates of all doses of vaccine and all negative lab reports.

☐ **Section 3: Hepatitis C** – lab report required with test dated within six months of program start date. If hepatitis C antibody is positive, a quantitative hepatitis C RNA test is required within six months of program start date.

☐ **Section 4: Tetanus, diphtheria, acellular Pertussis (Tdap)**
- One time adult dose of Tdap vaccine is required regardless of date If last tetanus dose. Tdap dose must have a date after 2005.
- Td (tetanus/diphtheria) boosters every 10 years thereafter

☐ **Section 5: Polio vaccine** – date and formulation of most recent dose.

☐ **Section 6: Meningitis vaccine** - date and formulation of most recent dose

☐ **Section 7: TB Screening**
- Two PPD (tuberculosis screening) skin tests administered 9-31 days apart, within six months of program start date.
  - Note: PPDs administered within 30 days after administration of a live-vaccine are not considered valid.
- Interferon Gamma Release Assays (IGRA) are acceptable for students who have received BCG vaccine.

✖ At this time, we do not accept IGRA blood tests (i.e. Quantiferon or T-spot) in lieu of skin tests for students involved with patient contact.

For people with a positive tuberculosis skin test or IGRA:

- You must complete a TB symptom questionnaire
- If you did not complete therapy for active or latent TB you must submit date and size in mm of induration of your skin test, and report of a chest x-ray completed in the last 12 months **OR**
- If completed therapy for active or latent TB, submit date and size in mm of induration of your skin test, report of x-ray completed at time of your conversion, and record of latent TB infection treatment.

☐ **Section 8: Optional Vaccines – date and formulations of other recommended but not required vaccinations**

☐ **Section 9: Attestation – clinician signature and office stamp required.**

☐ **Respirator Questionnaire** (PA, MD, and MDPHD students only – 2 pages) – complete and return the respirator medical evaluation questionnaire. A respirator (sometimes called "a duckbill") is a mask that can provide protection against certain bacterial and viral illness in the patient care setting. The mask must be "fit tested" to make sure there's a good seal but that can't happen unless we have this questionnaire completed.

**Instructions**

1. Complete all "self-report" documents – Patient Registration, Health History, Meningitis Waiver, Respirator (clinical students only)

2. Collect prior immunization records, titers, TB test and x-ray results. If these services were received outside of the U.S. documentation must be provided in English. Dates should be completed in mm/dd/yyyy format. Lab reports must include your name, date, name/location of laboratory, results and reference ranges. Screen shots or flow sheets from electronic record systems are not adequate documentation.

3. Arrange a visit with your healthcare provider. Show them these requirements. Get your Physical Exam and Immunization forms completed. You may need blood tests to measure serologic immunity as outlined above. You will need to complete your tuberculosis testing.

   It is important these requirements are met as outlined in this document

since requirements for health science students are much stricter than the general population.

4. After all requirements are satisfied, all forms signed and/or stamped, make a copy (or scan) of all materials for your records and then mail the originals to us by the appropriate deadline.

5. We will review all materials to verify compliance with our requirements. Note that if submitted documents do not meet our standards, you will be required to repeat missing requirements at SHS at your expense.

## Frequently Asked Questions

**What if I can't meet the submission deadline?**
You may not be able to register for coursework. Students with immunization deficiencies may be removed from academic activities under New York State law.

**I currently work or volunteer at a hospital. Can I use an Occupational/Employee Health Report to meet my requirements?**
No. While it is useful information it does not by itself meet our health requirements. You should have your healthcare provider complete our immunization form, and when possible, submit lab tests of immunity.

**I had varicella (chicken pox) as a child. Do I really need a titer?**
Immunity to varicella at our campus is demonstrated by positive lab test for varicella antibodies, or documentation of 2 doses of varicella vaccine administered 30 days apart, after your first birthday.

**I've received BCG vaccine and have been told I should not get a skin test. Do I really need a PPD? How about a blood test for TB?**
Our main clinical partner requires documentation of TB skin tests for students involved in patient contact. Prior immunization with BCG does not preclude testing for latent tuberculosis via skin test. While some of our affiliates might accept an interferon gamma release assay ("tb blood test") we must have skin test results on file.

**Can't I just do all this when I get to campus?**
No. Students must address requirements prior to arrival to campus. Those with significant deficiencies may have registration holds. Students not meeting immunization and meningococcal disease report requirements under NYS law within 30 days of the start of class may be placed on administrative leave.

**I completed everything as instructed but I am told I still have deficiencies. What does this mean?**
All submitted materials must meet our documentation standards and anything that doesn't will not count towards meeting your requirements. In the event you are told you have a deficiency you will be provided with instructions on how to resolve your issue.

**Where can I learn more about Student Health Services?**
Visit http://shs.med.cornell.edu to learn about our services, financial policy, and other important administrative information.

**Am I required to pay a fee for Student Health Services?**
All students in the MD, MDPHD, MSHS PA and PHD programs are required to pay a student health services fee and have access to all student health, mental health and counseling services. Students in a Master's Degree program or certificate program may opt of the health service fee under certain circumstances, but are still required to submit health forms, immunization records and will be charged an administrative document fee. Students who only pay an administrative document fee will not be eligible for any services.

**Where can I learn more about the student health insurance plan?**
Student Health Services does not administer the insurance plan. you will get more information about the health insurance plan, waiver process and optional dental and vision programs from your academic program.

**What insurance program does Student Health Services participate in?**
SHS is not in any insurance plans. All students who pay the health services fee, regardless of insurance, have access to Student Health Services. Insurance is required for prescriptions, labs and imaging tests, and any healthcare services provided outside of the student health center.

**Am I required to have a flu vaccine?**
Flu vaccine is required for all students with patient contact. All students who have patient contact and who start school between September and March must provide documentation of receipt a flu vaccine for the current season. Documentation must include the date, and name and address of the vaccine provider. Flu vaccine is provided yearly at no cost to eligible students.

**Is meningitis vaccination required?**
Meningitis vaccination is not required but we are required to provide you information about meningococcal disease and the availability of a vaccine. The next two pages provide information regarding meningococcal disease from the New York State Department of Health.

NEW YORK STATE | Department of Health

# Meningococcal Disease

## What is meningococcal disease?

Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Teenagers or young adults
- Infants younger than one year of age
- Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris® or, who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory

## What are the symptoms?

Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

## How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

## Is there treatment?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

## What are the complications?

Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

## What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

## What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older.

Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age, and the second dose (booster) at age 16.
  - It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
  - Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal strains A, C, W and Y.
- Teens and young adults can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend vaccine against the "B" strain.

Others who should receive the vaccine include:

- Infants, children and adults with certain medical conditions
- People exposed during an outbreak
- Travelers to the "meningitis belt" of sub-Saharan Africa
- Military recruits

Please speak with your health care provider if you may be at increased risk.

## What are the meningococcal vaccine requirements for school attendance?

As of September 1, 2016, children entering grades 7 and 12 must be immunized against meningococcal disease strains A, C, W and Y according to the recommendations listed above.

## Is there an increased risk for meningococcal disease if I travel?

- Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic.
- To reduce your risk of illness, wash your hands often, maintain healthy habits such as getting plenty of rest and try not to come into contact with people who are sick.

**Travel and meningococcal disease:**

wwwnc.cdc.gov/travel/diseases/meningococcal-disease

**Learn more about meningococcal disease:**

www.cdc.gov/meningococcal/

**For more information about vaccine-preventable diseases:** www.health.ny.gov/prevention/immunization/

# Weill Cornell Medicine
## Student Health Services

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## Patient Registration Form

Please print all entries. This information will be used to register you in the Weill Cornell Medicine enterprise medical record. At your first visit or contact with Student Health Services you will be required to provide additional information regarding source of payment for services (coverage) and guarantor (responsible party.) The only individuals with access to the information on this form are patient registration staff, practice administrators, your care providers and the people involved in quality improvement and oversight. Registration information is not shared with your academic program. The confidentiality of this information is protected by law.

| **PATIENT DEMOGRAPHICS** | | | | | |
|---|---|---|---|---|---|
| NAME (AS LISTED ON IDENTIFICATION)<br>Last, First | | PREFERRED NAME | | DATE OF BIRTH<br>(mm/dd/yyyy) | |
| SEX ASSIGNED AT BIRTH**<br><br>☐ FEMALE<br>☐ MALE<br>☐ INTERSEX | SEX LISTED WITH HEALTH INSURANCE**<br><br>☐ FEMALE<br>☐ MALE | WHAT IS YOUR GENDER IDENTITY?**<br><br>☐ SAME AS SEX LISTED WITH INSURANCE<br><br>☐ OTHER _____ | | PREFERRED PROUNOUNS**<br><br>☐ SHE/HER ☐ ZE/HIR ☐HE/HIS/HIM<br><br>☐ Other _____ | |
| STREET ADDRESS (No., street, apt #) | | | CITY | STATE | ZIP CODE |
| COUNTRY | HOME PHONE | CELL PHONE | E-MAIL ADDRESS | | |
| HISPANIC ETHNICITY?***<br><br>☐ YES ☐NO ☐UNKNOWN ☐ DECLINE | | RACE*** | ADDITIONAL RACE*** | ETHNICITY*** | |
| WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS? | | Do you require an interpreter?<br>☐YES<br>☐NO | MARITAL STATUS (choose one)<br>☐Divorced ☐Domestic Partnership<br>☐Legally Separated ☐Married ☐Single<br>☐Widowed ☐Unknown ☐Other | RELIGION | |
| **EMERGENCY CONTACTS** | | | | | |
| FULL NAME CONTACT #1 | | ADDRESS (No., Street, apt#, city, state, zip code) | | | |
| HOME PHONE | WORK NUMBER | CELL PHONE | RELATIONSHIP TO PATIENT | | |
| FULL NAME CONTACT #2 | | ADDRESS (No., Street, apt#, city, state, zip code) | | | |
| HOME PHONE | WORK NUMBER | CELL PHONE | RELATIONSHIP TO PATIENT | | |

☐ Please check here if you have ever been a patient, student, or employee at NewYork-Presbyterian Hospital-Weill Cornell Medical Center or Weill Cornell Physicians at Weill Cornell Medical College.

** Regarding Sex: Our EMR requires biological sex for patient registration, but we recognize that for many, sex isn't "binary".

*** Regarding Race/Ethnicity/Language/Religion:

We want to make sure that all our patients get the best care possible. We would like you to tell us your racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

# Weill Cornell Medicine
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### Medical and Mental Health History

The matriculating student must complete this form. All information disclosed on this form will be scanned into our campus-wide electronic medical record. Medical record information is confidential and will not be released outside Weill Cornell Medicine without your permission except as required by law. Please return your completed forms to Student Health Services, using our mailing address, along with any supplemental medical information that will help us provide you the best possible care.

**Part I: General information**

Name: _____
Last First MI
Date of birth (mm/dd/yyyy) ___/___/_____

Program: ❑ MD ❑ MD/PhD ❑ MSHS PA ❑ PhD ❑ MS
Program of Study (MS and PhD only) _____
❑ Male ❑ Female ❑ Transgender ❑ Other(specify)

Do you have any disabilities? ❑ No ❑ Yes- Specify: _____

If yes, will you require accommodations? ❑ No ❑ Yes- Specify: _____ (If yes, contact your program)

**Family History**

Are you adopted? ❑ No ❑ Yes

| Family member/Name | Current age | Age at death | Present health status; cause of death or any disease present |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sibling (sex __) | | | |
| Sibling (sex __) | | | |
| Sibling (sex __) | | | |
| | | | |

Have your blood relatives had any of the following?

| | Y | N | Relationship | | Y | N | Relationship |
|---|---|---|---|---|---|---|---|
| Alcoholism | ❑ | ❑ | | Emotional problems | ❑ | ❑ | |
| Allergies | ❑ | ❑ | | Headaches | ❑ | ❑ | |
| Arthritis | ❑ | ❑ | | Heart disease | ❑ | ❑ | |
| Asthma | ❑ | ❑ | | High blood pressure | ❑ | ❑ | |
| Cancer | ❑ | ❑ | | Kidney disease | ❑ | ❑ | |
| Cholesterol problem | ❑ | ❑ | | Intestinal problems | ❑ | ❑ | |
| Depression | ❑ | ❑ | | Learning disabilities | ❑ | ❑ | |
| Diabetes | ❑ | ❑ | | Lung disease/TB | ❑ | ❑ | |
| Drug/Substance Abuse | ❑ | ❑ | | Stomach disease | ❑ | ❑ | |
| Epilepsy/convulsions | ❑ | ❑ | | Stroke | ❑ | ❑ | |

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NAME _____

**Part II: Medical History**

1. Describe any ongoing health problems or conditions requiring medical care.

_____
_____
_____
_____

| Have you ever had any of the following | Yes | No | Details: Identify question by number, include diagnosis, age or dates, and treatment |
|---|---|---|---|
| 2. Adverse or allergic reaction to any medication | ❑ | ❑ | |
| 3. Adverse or allergic reaction to latex | ❑ | ❑ | |
| 4. Allergic reaction to food, insect bites, or other | ❑ | ❑ | |
| 5. Mononucleosis (Mono) | ❑ | ❑ | |
| 6. Mumps | ❑ | ❑ | |
| 7 German measles (Rubella) | ❑ | ❑ | |
| 8. Hard measles (Rubeola) | ❑ | ❑ | |
| 9. Chicken pox | ❑ | ❑ | |
| 10. Tuberculosis | ❑ | ❑ | |
| 11. Hospitalization | ❑ | ❑ | |
| 12. X-ray therapy to the head or neck | ❑ | ❑ | |
| 13. Operation or serious injury | ❑ | ❑ | |
| 14. List any medications with doses (prescription and non-prescription), and supplements, you use | | | |

_____
_____

| Have you ever had or been treated for any of the following: | | | |
|---|---|---|---|
| 15. Serious disease of eye, ears, nose, or throat | ❑ | ❑ | |
| 16. Lung disease, asthma, persistent cough, or shortness of breath | ❑ | ❑ | |
| 17. High blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels | ❑ | ❑ | |
| 18. Frequent or severe headaches or convulsions, or a severe head injury | ❑ | ❑ | |
| 19. Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem | ❑ | ❑ | |
| 20. Sugar, protein, or blood in urine, or bladder or kidney problem. | ❑ | ❑ | |
| 21. A sexually transmitted infection (STI) | ❑ | ❑ | |
| 22. Diabetes, thyroid, or other endocrine disorder | ❑ | ❑ | |
| 23. Anemia or other disorder of the blood | ❑ | ❑ | |
| 24. Bone, joint, or muscle problem; back pain; arthritis; physical deformity or paralysis | ❑ | ❑ | |
| 25. Hay fever, hives, or other allergy | ❑ | ❑ | |
| 26. Severe acne, eczema, or other skin disorder | ❑ | ❑ | |
| 27. Cancer or other tumor | ❑ | ❑ | |
| 28. A disorder not listed above (specify) | ❑ | ❑ | |

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NAME _____

| | Yes | No | |
|---|---|---|---|
| **Social Habits. Do you…** | | | |
| 29. Drink alcoholic beverages? (Specify type and average number of drinks per week) | ❑ | ❑ | |
| 30.Have any religious/spiritual beliefs that may impact your healthcare? Specify | ❑ | ❑ | |
| 31. Have a special diet? (Explain) | ❑ | ❑ | |

32. Use tobacco? ❑ Never Smoker ❑ Current Smoker ❑ Former Smoker. If Current/Former, indicate what _____ how much _____ how long ____(years) Please include electronic cigarette use in this category.

33. Use smokeless tobacco? ❑ Never Used ❑Current User ❑ Former User Type: ❑ Snuff ❑ Chew ❑ "

| | | | |
|---|---|---|---|
| **Women Only** | | | |
| 34. Have you ever had a menstrual disorder or disorder of the female organs? | ❑ | ❑ | |
| 35. Have you ever had a pelvic exam and Pap smear? (Specify dates and findings of your most recent exam; you can have your physician send copies) | ❑ | ❑ | |
| 36. Do you do a monthly breast self-exam? | ❑ | ❑ | |
| 37. Do you use hormonal contraception? | ❑ | ❑ | |
| 38. Do you use any other form of contraception? (Please specify) | ❑ | ❑ | |
| **Men Only** | | | |
| 39. Have you ever had any disorder of the penis, testicles, or prostate? | ❑ | ❑ | |
| 40. Do you do a monthly testicular self exam? | ❑ | ❑ | |
| 41. Do you use condoms consistently with your sexual partners? | ❑ | ❑ | |

## Part III: General Wellness Information

| | | | |
|---|---|---|---|
| Do you regularly engage in any form of exercise | ❑ | ❑ | |
| Do you have any major health concerns as you come to Weill Cornell | ❑ | ❑ | |
| Is there anything else you wish to share with us that hasn't been covered? Use blank space below. | ❑ | ❑ | |

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**Part IV: Mental Health History**

Name _____

1. Describe any medical or mental health problems or conditions that have required psychological or psychiatric care.

_____
_____
_____
_____
_____

| Have you had or experienced any of the following | Yes | No | Details: Identify question by number, include diagnosis, age or dates, and treatment |
|---|---|---|---|
| 2. Depression | ❑ | ❑ | |
| 3. An anxiety disorder | ❑ | ❑ | |
| 4. An eating disorder | ❑ | ❑ | |
| 5. Bipolar disorder | ❑ | ❑ | |
| 6. Obsessive-compulsive disorder | ❑ | ❑ | |
| 7. An anger management issue | ❑ | ❑ | |
| 8. PTSD | ❑ | ❑ | |
| 9. ADD/ADHD | ❑ | ❑ | |
| 10. A suicide attempt | ❑ | ❑ | |
| 11. Thoughts of suicide | ❑ | ❑ | |
| 12. Self harm (e.g., cutting) | ❑ | ❑ | |
| 13. A sleep disorder | ❑ | ❑ | |
| 14. Panic disorder | ❑ | ❑ | |
| 15. A learning disability | ❑ | ❑ | |
| 16. An anti-social or conduct disorder | ❑ | ❑ | |
| 17. Alcohol or substance abuse or dependence | ❑ | ❑ | |
| 18. Are you taking or have you ever taken medication for any of the above? (specify medication and dates) | ❑ | ❑ | |
| 19. Have you been hospitalized for a psychiatric disorder | ❑ | ❑ | |
| 20. Have you been treated for alcohol and/or drug addiction? (specify dates) | ❑ | ❑ | |
| 21. Are you currently being treated by: a psychiatrist? | ❑ | ❑ | |
| A psychotherapist (counselor, psychologist, social worker) | ❑ | ❑ | |
| Other mental health professional? | ❑ | ❑ | |

I hereby certify that the above general, medical, wellness and mental health information is complete and accurate to the best of my knowledge.

Signed _____ Date _____

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## Student Health Services

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**MATRICULATING STUDENT PHYSICAL EXAMINATION FORM**
(Must be completed by a licensed physician, nurse practitioner or physician assistant who is *not* a relative)

**Student Information:**

Name: _____
Last First MI
Date of birth (mm/dd/yyyy) ___/___/_____

Program: ❑ MD ❑ MD/PhD ❑ MSHS PA ❑ PhD ❑ MS
Program of Study (MS and PhD only) _____
❑ Male ❑ Female ❑ Transgender ❑ Other (specify)

**History:**

Any significant past medical or mental health history? ❑ No ❑ Yes:
Specify:_____
_____

Alcohol use: ❑ No ❑ Yes: Specify drinks/week: _____
Tobacco use ❑ No ❑ Yes: Specify type and amount/week _____
Other drug use: ❑ No ❑ Yes: Specify substance and frequency_____
Any allergies to medications? ❑ No ❑ Yes: Specify agent(s) and reaction(s): _____
Any latex or other non-medication allergies? ❑ No ❑ Yes: Specify agent(s) and reaction(s): _____
Please list **ALL** current medications and doses, including contraceptives, non-prescription medications, vitamins, herbals, and supplements: ❑ None

_____
_____

**Physical Exam**

Visual acuity (with correction if any) OD 20/___ OS 20/___ OU 20/___ Color Vision: Pass/Fail Correction? ❑ No ❑ Yes
Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse: _____

| | Normal | Abnormal | Not Done | If abnormal, comments |
|---|---|---|---|---|
| General appearance | ❑ | ❑ | ❑ | _____ |
| Head | ❑ | ❑ | ❑ | _____ |
| Eyes | ❑ | ❑ | ❑ | _____ |
| Ears, Nose, Throat | ❑ | ❑ | ❑ | _____ |
| Neck | ❑ | ❑ | ❑ | _____ |
| Skin | ❑ | ❑ | ❑ | _____ |
| Lymph nodes | ❑ | ❑ | ❑ | _____ |
| Heart | ❑ | ❑ | ❑ | _____ |
| Lungs | ❑ | ❑ | ❑ | _____ |
| Abdomen | ❑ | ❑ | ❑ | _____ |
| Spine | ❑ | ❑ | ❑ | _____ |
| Extremities | ❑ | ❑ | ❑ | _____ |
| Neurological Exam | ❑ | ❑ | ❑ | _____ |

I certify that I this student is free of health impairment that would pose a potential risk to patients or others. ❑ No ❑ Yes
Does this student require ongoing medical care for any health problems? ❑ No ❑ Yes: Specify: _____
_____

Clinician Signature: _____ Exam Date (mm/dd/yyyy): _____
Printed Name: _____ State and License Number: _____
Office Address: _____
Office Telephone _____ Office Fax: _____
Office Stamp:

# Weill Cornell Medicine
## Student Health Services

Please do not staple and do not print double sided

**MENINGITIS INFORMATION 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 and return the following form to:

Weill Cornell Medicine
Student Health Services
1300 York Ave Box 258
New York, NY 10065

**Check one box and sign below.**

❑ I have had meningococcal meningitis immunization within the past 5 years. The vaccine record is attached.

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least one dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

❑ I have read, or have had explained to me the information regarding meningococcal disease. I will obtain immunization against meningococcal disease **within 30** days from my private health care provider.

[Note: Routine meningococcal vaccination is **not** available at Weill Cornell Medicine Student Health Services but may be available from local retail pharmacies or other local healthcare providers in your insurance plan]

❑ I have read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal disease

_____ _____
Signature Date Signed

_____ _____ _____
Printed Student's Name Student Date of Birth Student ID (if known)

_____ _____
Student's E-mail Student's phone

_____
Student's Mailing Address

Source: New York State Department of Health – June 2016

# Weill Cornell Medicine
## Student Health Services

Please do not staple and do not print double sided

Name _____ DOB _____

### Immunization History and Tuberculosis Screening

Inability to receive a vaccine for a *medical reason* (i.e. vaccine allergy) requires documentation from your physician. *Philosophical and religious exemptions are not available for health sciences students*. For students unable to obtain titers, clinician should document vaccination dates. Record all dates in MM/DD/YYYY format and ATTACH ALL LAB AND CHEST X-RAY REPORTS.

❑ **Section 1: Immunity to Measles, Mumps, Rubella, and Varicella** (attach lab reports if available)

- Measles Titer (igG) Result Date: _____ Result: ❑ POS ❑ NEG
- Mumps Titer (IgG) Result Date: _____ Result: ❑ POS ❑NEG
- Rubella Titer (IgG) Result Date: _____ Result: ❑ POS ❑ NEG
- Varicella Titer (IgG) Result Date: _____ Result: ❑ POS ❑ NEG

Vaccination Dates:
MMR #1 _____ MMR#2 _____ MMR#3 (if given) _____
Varicella #1 _____ Varicella #2 _____ Varicella #3 (if given) _____

❑ **Section 2: Immunity to Hepatitis B – within last 6 months** (attach lab reports)
Documentation of completed Hep B series AND post-immunization titer is required for all students.
Hep B #1 _____(date) Hep B #2 _____ (date) Hep B #3 _____(date)
Hepatitis B Surface Antibody (IgG) Result Date: _____ Result: ❑ POS ❑ NEG

*Proceed to section 3 if Hep B immune. If Hepatitis B surface antibody testing does not show immunity*:
Hepatitis B Surface Antigen Result Date: _____ Result: ❑ POS ❑ NEG
Additional Hep B doses (if initial post-immunization test AND hep B surface antigen are negative)
Hep B #4 _____(date) Hep B #5 _____ (date) Hep B #6 _____(date)
Repeat Hepatitis B Surface Antibody (IgG) Result Date: _____ Result: ❑ POS ❑ NEG

❑ **Section 3: Testing for Hepatitis C – within last 6 months** (attach lab reports)
HCV Antibody Test Result Date: _____ Result: ❑ POS ❑ NEG

❑ **Section 4: Immunity to Tetanus and Pertussis**
Most recent Td booster _____ (date within last 10 years) Type: ❑ Td ❑ Tdap (Adacel or Boostrix)
Most recent Tdap _____ (must be after 2005)

❑ **Section 5: Immunity to Polio**
Most recent polio booster _____ (date) Type: ❑ IPV ❑ OPV
Name _____ DOB _____

❑ **Section 6: Meningococcal Vaccination**

- Meningitis A, C, W, Y Vaccination Date: _____ Brand/Type: _____
- Meningitis B Vaccination Dates: _____ _____ _____ Brand: _____

❑ **Section 7: Tuberculosis Screening (skin test OR blood test)** (attach IGRA report if done; attach chest x-ray report if done)

Please do not staple and do not print double sided.

Name _____ DOB _____

*Note to clinician: If this student is enrolling in the MD, MDPHD or PA program and does not have a history of a prior positive TB skin test, the student must undergo 2-step tuberculin skin testing. If this student is in any other degree program and/or has received BCG vaccine, the student may undergo IGRA testing.*

*A cut-off of 10mm of induration is used to define a positive skin test in health care workers, including health science students, and a cut-off of 5 mm is used for patients on immunosuppressant medications or chronic condition affecting the immune system, as well as for those with a recent TB exposure. IGRAs and skin tests must not be performed within 30 days after administration of a live virus vaccine.*

❑ **Tuberculin skin test #1** (within 12 months of the start of program):
Date Placed_____ Date Read _____Size: _____ (mm of induration) ❑ POS ❑ NEG

**Tuberculin skin test#2** (within 90 days of the start of program):
Date Placed_____ Date Read _____Size: _____ (mm of induration) ❑ POS ❑ NEG
**OR**
❑ **IGRA:** Brand _____ _____ (date must be within 90 days of start of program) ❑ POS ❑ NEG

If tuberculin skin test or IGRA is POSITIVE, clinician must complete the following:

Chest X-ray _____ (date must be within 12 months of program start) ❑ Normal ❑ Not normal

Did student complete INH or comparable treatment? ❑ Yes ❑ No _____

**Clinician: Please ask these screening questions of the patient with a positive TB skin test or positive IGRA only**

| | | | |
|---|---|---|---|
| History of BCG? | ❑ Yes ❑ No | Year: _____ | Country:_____ |
| Have you traveled and/or lived overseas in the past year? | ❑ Yes ❑ No | If yes, where: _____ | Most recent return date: _____ |
| Have you worked in a prison or homeless shelter in the past year | ❑ Yes ❑ No | Have you entered a TB isolation room in the past year? | ❑ Yes ❑ No |
| Have you had exposure to a known case of TB in the past year? | ❑ Yes ❑ No | | |

In the past six months have you experienced any of the following for **greater than three weeks?**

| | | | |
|---|---|---|---|
| Excessive sweating at night | ❑ Yes ❑ No | Coughing up blood | ❑ Yes ❑ No |
| Excessive weight loss | ❑ Yes ❑ No | Hoarseness | ❑ Yes ❑ No |
| Persistent coughing | ❑ Yes ❑ No | Persistent Fever | ❑ Yes ❑ No |
| Excessive Fatigue | ❑ Yes ❑ No | | |

❑ **Section 8: Optional Vaccines** – provide dates of the following if available.

- Hepatitis A #1_____ #2_____ #3_____
- HPV #1 _____ Type: _____ #2_____ Type: _____ #3_____ Type: _____
- Japanese Encephalitis _____ _____:
- Rabies #1 _____ #2_____ #3_____
- Typhoid _____ Type: _____
- Yellow Fever _____

Please do not staple and do not print double sided.

Name _____ DOB _____

❑ **Section 9: Attestation**

I certify that I performed a physical exam on the above named student and reviewed immunization and tuberculosis screening records. This individual is in good health and is free of contagious disease. To the best of my knowledge this individual is free from any impairment which may jeopardize the health of patients, or which may interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior. I attest that all dates, results, and immunizations listed on this form are correct and accurate.

Clinician Name and Title: _____ Office Address Stamp:

Signature:_____ Date: _____

Please remember to attach lab reports or lab result printouts from an EMR. Do not simply provide the patient with screen shots or flowsheets. Thank you.

# OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

(only for students with patient contact)

**PLEASE ANSWER THIS QUESTIONNAIRE DURING NORMAL WORKING HOURS, OR AT A TIME AND PLACE THAT IS CONVENIENT TO YOU. TO MAINTAIN YOUR CONFIDENTIALITY RETURN THIS TO YOUR SUPERVISOR IN A SEALED ENVELOPE OR DIRECTLY TO STUDENT HEALTH SERVICES (SHS)**

**THE FOLLOWING INFORMATION MUST BE PROVIDED BY EVERY STUDENT TRAINEE WHO HAS BEEN SELECTED TO USE ANY TYPE OF RESPIRATOR. PLEASE PRINT, OR PLEASE CIRCLE ONE OF THE ANSWERS TO THE FOLLOWING QUESTIONS:**

**1.** Today's date:_____ **2.** Name & Date of Birth _____

**3.** Age (to nearest year):_____ **4.** Sex: Male Female

**5.** Height: _____ ft. _____ in. **6.** Weight: _____ lbs.

**7.** Job title: HEALTH PROFESSIONS STUDENT

**8.** Academic Program: _____

**9.** A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

**10.** The best time to phone you at this number: _____

**11.** Circle the type of respirator you will use (you can choose more than one category): (students will usually use a.)

**a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).**

b. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

**12.** Have you worn a respirator (circle one): **Yes** **No**

If "yes" what type(s) (circle all that apply):

**a.** particulate respirator (isolation/TB mask/filter mask)
**b.** full face mask
**c.** self-contained breathing apparatus
**d.** other (explain) _____

**13.** Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month? **Yes** **No**

**14.** Have you ***ever had*** any of the following conditions?

| | | |
|---|---|---|
| **a.** Seizures (fits) | **Yes** | **No** |
| **b.** Diabetes (sugar disease) | **Yes** | **No** |
| **c.** Allergic reactions that interfere with your breathing | **Yes** | **No** |
| **d.** Claustrophobia (fear of closed-in places) | **Yes** | **No** |
| **e.** Trouble smelling odors | **Yes** | **No** |

**15.** Have you ***ever had*** any of the following pulmonary or lung problems?

| | | |
|---|---|---|
| **a.** Asbestosis | **Yes** | **No** |
| **b.** Asthma | **Yes** | **No** |
| **c.** Chronic bronchitis | **Yes** | **No** |
| **d.** Emphysema | **Yes** | **No** |
| **e.** Pneumonia | **Yes** | **No** |
| **f.** Tuberculosis | **Yes** | **No** |
| **g.** Silicosis | **Yes** | **No** |
| **h.** Pneumothorax (collapsed lung) | **Yes** | **No** |
| **i.** Lung cancer | **Yes** | **No** |
| **j.** Broken ribs | **Yes** | **No** |
| **k.** Any chest injuries or surgeries | **Yes** | **No** |
| **l.** Any other lung problem that you've been told about | **Yes** | **No** |

**16.** Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?

| | | |
|---|---|---|
| **a.** Shortness of breath | **Yes** | **No** |
| **b.** Shortness of breath when walking fast on level ground or walking up a slight hill or incline | **Yes** | **No** |
| **c.** Shortness of breath when walking with other people at an ordinary pace on level ground | **Yes** | **No** |
| **d.** Have to stop for breath when walking at your own pace on level ground | **Yes** | **No** |
| **e.** Shortness of breath when washing or dressing yourself | **Yes** | **No** |
| **f.** Shortness of breath that interferes with your job | **Yes** | **No** |
| **g.** Coughing that produces phlegm (thick sputum) | **Yes** | **No** |
| **h.** Coughing that wakes you early in the morning | **Yes** | **No** |
| **i.** Coughing that occurs mostly when you are lying down | **Yes** | **No** |
| **j.** Coughing up blood in the last month | **Yes** | **No** |
| **k.** Wheezing | **Yes** | **No** |
| **l.** Wheezing that interferes with your job | **Yes** | **No** |
| **m.** Chest pain when you breathe deeply | **Yes** | **No** |
| **n.** Any other symptoms that you think may be related to lung problems | **Yes** | **No** |

Source: Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire

**NAME** _____

**17.** Have you ***ever had*** any of the following cardiovascular or heart problems?

| | | |
|---|---|---|
| **a.** Heart attack | **Yes** | **No** |
| **b.** Stroke | **Yes** | **No** |
| **c.** Angina | **Yes** | **No** |
| **d.** Heart failure | **Yes** | **No** |
| **e.** Swelling in your legs or feet (not caused by walking) | **Yes** | **No** |
| **f.** Heart arrhythmia (heart beating irregularly) | **Yes** | **No** |
| **g.** High blood pressure | **Yes** | **No** |
| **h.** Any other heart problem that you've been told about | **Yes** | **No** |

**18.** Have you ***ever had*** any of the following cardiovascular or heart symptoms?

| | | |
|---|---|---|
| **a.** Frequent pain or tightness in your chest | **Yes** | **No** |
| **b.** Pain or tightness in your chest during physical activity | **Yes** | **No** |
| **c.** Pain or tightness in your chest that interferes with your job | **Yes** | **No** |
| **d.** In the past two years, have you noticed your heart skipping or missing a beat | **Yes** | **No** |
| **e.** Heartburn or indigestion that is not related to eating | **Yes** | **No** |
| **f.** Any other symptoms that you think may be related to heart or circulation problems: | **Yes** | **No** |

**19.** Do you ***currently*** take medication for any of the following problems?

| | | |
|---|---|---|
| **a.** Breathing or lung problems | **Yes** | **No** |
| **b.** Heart trouble | **Yes** | **No** |
| **c.** Blood pressure | **Yes** | **No** |
| **d.** Seizures (fits) | **Yes** | **No** |

**20.** If you've used a respirator, have you ***ever had*** any of the following problems? (If you've never used a respirator, check the following space and go to question 21 _____)

| | | | |
|---|---|---|---|
| **a.** | Eye irritation | **Yes** | **No** |
| **b.** | Skin allergies or rashes | **Yes** | **No** |
| **c.** | Anxiety | **Yes** | **No** |
| **d.** | General weakness or fatigue | **Yes** | **No** |
| **e.** | Any other problem that interferes with your use of a respirator | **Yes** | **No** |

**21.** Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? **Yes** **No**

**22.** Have you ***ever lost*** vision in either eye (temporarily or permanently)? **Yes** **No**

**23.** Do you ***currently*** have any of the following vision problems?

| | | |
|---|---|---|
| **a.** Wear contact lenses | **Yes** | **No** |
| **b.** Wear glasses | **Yes** | **No** |
| **c.** Color blind | **Yes** | **No** |
| **d.** Any other eye or vision problem | **Yes** | **No** |

**24.** Have you ***ever had*** an injury to your ears, including a broken ear drum? **Yes** **No**

**25.** Do you ***currently*** have any of the following hearing problems?

| | | |
|---|---|---|
| **a.** Difficulty hearing | **Yes** | **No** |
| **b.** Wear a hearing aid | **Yes** | **No** |
| **c.** Any other hearing or ear problem | **Yes** | **No** |

**26.** Have you ***ever had*** a back injury: **Yes** **No**

**27.** Do you ***currently*** have any of the following musculoskeletal problems?

| | | |
|---|---|---|
| **a.** Weakness in any of your arms, hands, legs, or feet | **Yes** | **No** |
| **b.** Back pain | **Yes** | **No** |
| **c.** Difficulty fully moving your arms and legs | **Yes** | **No** |
| **d.** Pain or stiffness when you lean forward or backward at the waist | **Yes** | **No** |
| **e.** Difficulty fully moving your head up or down | **Yes** | **No** |
| **f.** Difficulty fully moving your head side to side | **Yes** | **No** |
| **g.** Difficulty bending at your knees | **Yes** | **No** |
| **h.** Difficulty squatting to the ground | **Yes** | **No** |
| **i.** Climbing a flight of stairs or a ladder carrying more than 25 lbs | **Yes** | **No** |
| **j.** Any other muscle or skeletal problem that interferes with using a respirator | **Yes** | **No** |

Thank you. Your responses will be reviewed by a health care professional at Student Health and a determination made for medical suitability for respirator fit testing made. You will be notified if you require additional medical evaluation.
Fit testing will be conducted by staff from WCMC's Office of Environmental Health & Safety.

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**SHS STAFF USE ONLY**

❑ Medically cleared for Fit Testing of N, R, or P disposable respirator (isolation/TB/filtermask, non-cartridge type only).

❑ Medically cleared for other type (i.e. half or full-face piece type, powered-air purifying, SCBA).

❑ Is NOT permitted to use a respirator.

❑ Needs further medical interview in Student Health Services

❑ Has specific use restrictions:

_____

_____ _____
SHS Signature Date

Source: Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire