TO: School of Health Sciences and Practice, Department of Physical Therapy
    Incoming First Year Students 2023

FROM: Marisa Montecalvo MD, Director, Health Services

DATE: November 15, 2022

RE: Health Requirements – Directions

Welcome to the Doctorate of Physical Therapy program of the School of Health Sciences and Practice at New York Medical College! Attached please find a checklist of your Health requirements and all forms.

ALL requirements must be completed by March 15, 2023.

In order to attend orientation and begin classes, you must have completed ALL health requirements unless there is a medical reason to delay completion of a particular requirement in which case you may be issued a provisional clearance that will require follow-up. Please proceed as follows:

1. Schedule an appointment with your health care provider NOW. You may need blood tests and vaccine boosters that can take up to a few months to complete.

2. Send the completed packet as a PDF to Health_Services@nymc.edu. If you need a FAX option please use the FAX above 914-594-4692.

3. Check your NYMC email 3 business days after sending in your forms to check your status. Health Services can ONLY communicate with you using this email as this is a confidential email issued from your health record at NYMC.

4. Be sure your NYMC email is set up. For assistance use: TouroOne Portal First Time User. If you have any questions please email helpdesk@nymc.edu or call 914-594-2000.

5. Keep a copy for yourself of the completed forms, your vaccine records, your TB tests, and any blood tests performed for clearance.

6. Call Health Services 914-594-4234 if you have questions.
Health Services Requirements for Students of School of Health Sciences and Practice  
**Doctorate in Physical Therapy or Masters in Speech and Language Pathology**

Bring these forms including this checklist to your physician.  
All vaccines and laboratory test information MUST INCLUDE the vaccine administration record and the actual result from the laboratory.

<table>
<thead>
<tr>
<th>1. Medical History and Physical Exam:</th>
<th>This packet must be completed by both the student and the health care professional. Incomplete forms will be returned.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Release of records Form</td>
<td>To be signed and dated by student</td>
</tr>
</tbody>
</table>
| 3. Meningococcal Vaccine Response Form | Student to check category and sign.  
Attach vaccine records of any meningococcal vaccination received. |
| 4. COVID-19 Vaccination              | Primary Vaccination plus a booster when eligible  
PDF of CDC Vaccine Card(s) with all COVID-19 Vaccines Received. |
| 5. TB Screening                      | Within 12 months of school start date:  
An IGRA / QuantiFERON- TB OR  
2 step Tuberculin skin test.  
2<sup>nd</sup> TST is done 1-3 weeks after the 1<sup>st</sup>.  
Chest x-ray (with radiologist’s report) required and dated after positive TST/IGRA. |
| 6. Hepatitis B Virus (HBV) Immunity   | Full series (3 doses) of HBV vaccine PLUS a HBV panel = HBV surface antibody, HBV surface Ag, and HBV core antibody.  
Non-immune students with a negative HBV surface antibody are to receive an HBV booster vaccine and a repeat HBV surface Ab 30 days after the booster. |
| 7. Measles, Mumps, Rubella (MMR) Immunity | Beginning on or after age one:  
2 MMR (at least 28 days apart), or 2 measles, 1 mumps and 1 rubella vaccine  
OR quantitative titers for measles, mumps & rubella antibody. |
| 8. Varicella Immunity                | Two varicella vaccines OR quantitative titer for varicella antibody. |
| 9. Tetanus Diphtheria Pertussis Vaccine | A Tetanus of Tdap booster within ten years of school start date.  
Tdap preferred. |

11/22/2022
New York Medical College
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

HEALTH SERVICES

Medical History and Physical Exam

Return ONLY after completed by BOTH student and health care professional.

Enter your full name below and at top of each page:

Last Name

First Name

Please indicate your NYMC School/Program by checking the appropriate box below:

<table>
<thead>
<tr>
<th>School of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touro College of Dental Medicine</td>
</tr>
<tr>
<td>Clinical Laboratory Sciences Program (CLS) Graduate School of Biomedical Sciences</td>
</tr>
<tr>
<td>Graduate School of Biomedical Sciences, All programs other than CLS</td>
</tr>
<tr>
<td>Speech and Language Pathology Program, School of Health Sciences and Practice</td>
</tr>
<tr>
<td>Doctor of Physical Therapy Program, School of Health Sciences and Practice</td>
</tr>
</tbody>
</table>

FOR OFFICE USE ONLY
Date Received: ______________
## General Information

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex (M/F)</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Physical Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Cell#</td>
<td>Home#</td>
<td></td>
</tr>
</tbody>
</table>

**Physician’s Name**

<table>
<thead>
<tr>
<th>Physician's Phone#</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
</table>

**Name of Health Insurance Company**

<table>
<thead>
<tr>
<th>Policy ID#</th>
<th>Policy Group#</th>
<th>Prescription #</th>
</tr>
</thead>
</table>

**Name of Health Insurance Policy Holder**

<table>
<thead>
<tr>
<th>Policy Holder Date of Birth:</th>
<th>Policy Holder Relationship to Student</th>
</tr>
</thead>
</table>

☐ Check here if you are the Policy Holder

**Name of Emergency Contact**

<table>
<thead>
<tr>
<th>Relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home phone #</th>
<th>Cell phone #</th>
<th>Work phone #</th>
</tr>
</thead>
</table>

## Current and Past Medical History

- **Have you had surgery?**  
  - ☐ No  
  - ☐ Yes – Specify procedure(s) and year

- **Have you been hospitalized?**  
  - ☐ No  
  - ☐ Yes – Specify reason(s) for hospitalization and year

- **Do you have past medical condition(s)?**  
  - ☐ None  
  - ☐ Yes; Please specify past conditions

- **Do you have current medical condition(s)?**  
  - ☐ None  
  - ☐ Yes; Please specify past conditions

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NYMC Health Services helps connect students in need of ongoing care. Please call our office (914) 594-4234 for assistance.
Applicant Last Name/ First Name:

**NYMC offers No-Cost Mental Health Services with 24/7 Support** (see and please keep the flyer in this packet)
Questions? Call NYMC Mental Health Services (914) 594-2538 or visit us at [NYMC Student Mental Health & Wellness](#)

<table>
<thead>
<tr>
<th>Have you previously experienced, or do you currently have any mental health condition(s)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Anxiety</td>
</tr>
<tr>
<td>☐ Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>☐ Other (please specify)</td>
</tr>
</tbody>
</table>

**Medications:**

<table>
<thead>
<tr>
<th>Are you currently taking any medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you have allergies to medications, food other?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Family History:**

List any significant family history: List disease and relationship

**Personal and Social History**

<table>
<thead>
<tr>
<th>Have you lived outside the U.S. for more than one month?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you or do you smoke/ vape?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you feel that you are habitually using any drugs or alcohol?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
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</table>

**Review of Systems:** Please indicate by checking the appropriate box, or list the condition in the system; Specify if other

<table>
<thead>
<tr>
<th>General: ☐ weight gain, ☐ weight loss</th>
<th>GI: ☐ constipation, ☐ diarrhea, ☐ rectal bleeding, ☐ stomach pains, ☐ hepatitis, ☐ other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin: ☐ rashes, ☐ other</td>
<td>GU: ☐ blood in urine, ☐ testicular lumps, ☐ other</td>
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<tr>
<td>HEENT: ☐ head injury, ☐ hearing disorder</td>
<td>GYN: ☐ abnormal menses, ☐ other</td>
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<tr>
<td>Neck: ☐ swollen glands, ☐ thyroid disorder</td>
<td>Blood or Immune disorder - ☐ If yes, please specify:</td>
</tr>
<tr>
<td>Lungs: ☐ wheezing, ☐ infections, ☐ other</td>
<td>Neurologic: ☐ headaches, ☐ seizures, ☐ vision disorder</td>
</tr>
<tr>
<td>Cardiac: ☐ high/low blood pressure, ☐ cardiac disorder</td>
<td>Skeletal: ☐ joint pain, ☐ back problems, ☐ other:</td>
</tr>
<tr>
<td>Endocrine: ☐ diabetes, ☐ thyroid disorder, ☐ other</td>
<td>Psychiatric: ☐ anxiety, ☐ sleep issues, ☐ mood swings, ☐ depression</td>
</tr>
</tbody>
</table>

3 | Page
For Completion by Health Care Professional

**TUBERCULOSIS (TB) RISK ASSESSMENT as per NYSDOH guidelines**

1. Country of Birth of the Patient

2. History of residence (for >= 1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, Western or Northern Europe) □ No □ Yes Specify

   **Country:**
   **Dates: (From ___ until ___)**

3. Did the patient receive BCG vaccination? □ No □ Yes

4. Is the patient receiving any immune suppressive therapy or planned immune suppression? □ No □ Yes Specify

   **List medication(s) or disease:**
   **Duration of immune suppression and date/year when treatment received:**

5. Has the patient had close contact with anyone with TB disease? □ No □ Yes Specify

   **Specify contact and when it occurred:**

6. Has the patient ever had a positive tuberculin skin test (TST) or IGRA (Quantiferon) or evidence of TB? □ No □ Yes: Specify

   **Test Date:**
   **For TST, provide mm:**
   **For IGRA, Lab report of prior test is provided: Check here: □**

   **CXR after positive TST or IGRA:**
   **CXR Date:**
   **CXR report attached to this form: Check here: □**

7. Has the patient ever been treated for latent TB or active TB? □ No □ Yes Specify

   **Medications**
   **Dates Medication Received**

8. **TB Symptom Survey For Persons with History of Latent or Active TB:** Check here if *not* applicable □

   Specify details below if the patient has any of the following symptoms: Persistent cough > 2 weeks; Cough producing phlegm or blood; Enlarged lymph nodes in the neck or upper chest; Unexplained fever or night sweats or chills for longer than 2 weeks; Unexplained weight loss of >= 5 lbs.

---

**TB Screening for Students with NO History of Latent/Active TB**

Can be done by IGRA (Quantiferon) OR 2 step TST performed within 12 months of school start date. The 2nd TST is administered 1-3 weeks after the initial test.

**For TST performed at visit:** Lot # __________ TST Lot # Expiration Date __________

Date TST placed __/__/___ TST Result (positive / negative) and mm: __________ __________ mm

Date TST read __/__/___ If newly positive TST: Date of CXR ordered ___/___/___

**2nd TST:** Lot # __________ TST Lot # Expiration Date __________

Date TST placed __/__/___ TST Result (positive / negative) and mm: __________ __________ mm

Date TST read __/__/___ If newly positive TST: Date of CXR ordered ___/___/___
**PHYSICAL EXAMINATION**

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Height</th>
<th>Weight</th>
<th>Temp</th>
<th>Pulse</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>General:</td>
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<td>Skin:</td>
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<td>Abdomen:</td>
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<td>HEENT &amp; Neck:</td>
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<td>Extremities:</td>
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<td>Lungs:</td>
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<td>Musculoskeletal:</td>
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<td>Heart:</td>
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<td>Neurologic:</td>
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<td>Breasts/ Testicles:</td>
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<td>Other Findings:</td>
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**HEALTH PROVIDER ASSESSMENT**

- [ ] Check here after you have reviewed the student medical information and the checklist of required vaccines/tests.

**Assessment: Please check one:**

- [ ] The applicant is in good physical and mental health and has **no medical limitation** for pursuing graduate studies in the health professions or basic medical sciences.

- [ ] The applicant has the following medical or mental health condition(s) for which the **continuation of care is required**. Please provide a complete description below of the care required.

---

**Provider Name (print)** (please print)  
**State and License#**

Signature  
Date  
Phone Number
New York Medical College Meningococcal Vaccination Response Form

New York State Public Health Law 2167 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 this form.

The Advisory Committee on Immunization Practices (ACIP) recommends that all first-year college students up to 21 years of age have at least 1 dose of Meningococcal ACWY (MenACWY) vaccine (Brand names: Menactra, Menvio) preferably on or after the 16th birthday, which protects against 4 major strains of bacteria that cause meningococcal disease. Persons 16 through 23 years of age may choose to receive the Meningococcal B (MenB) vaccine series (Brand names: Trumenba, Bexsero) which protects against a 5th strain of meningococcal bacteria. College and university students should discuss the MenB vaccine with a healthcare provider.

Check one box and sign below:

☐ I have reviewed the information below. I had meningococcal immunization (MenACWY and/or MenB) in the past 5 years. The vaccine record is attached.

☐ I have reviewed the information below and I will obtain meningococcal immunization within 30 days from an appropriate health care provider.

☐ I have reviewed the information below. I understand the risks of meningococcal meningitis and the benefits of immunization at the recommended ages. I have decided that I will not obtain immunization against meningococcal disease at this time.

Signed: ____________________________ Date: ____________________________

Student’s name (Print): ____________________________ Student Date of Birth: ____________________________

Meningococcal Disease and Meningococcal Vaccine Information: (from the New York State Dept of Health)

What is Meningococcal Disease? Meningococcal disease is caused by bacteria called Neisseria meningitidis. Infection can start with flu-like symptoms, but it can cause serious illness such as infection of the brain and spinal column (meningitis) or bloodstream infections (sepsis). The disease can strike quickly and can lead to severe and permanent disabilities such as hearing loss, brain damage, seizures, limb amputation and even death.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing or spending time in close contact with someone who is sick or carries the bacteria. People can spread the bacteria even before they know they are sick. There have been several outbreaks of meningococcal disease at university campuses in the United States. The single best way to prevent meningococcal disease is to be vaccinated.

Who needs Meningococcal Vaccination and how do I obtain it? The ACIP recommendations for immunization are listed at the top of this form. Contact your health insurance plan to determine whether it covers the MenACWY and MenB vaccines. The federal Vaccines for Adults program will cover the cost of these vaccines for those who have no health insurance or whose health insurance does not cover these vaccines. Contact your local health department to find out about the Vaccines for Adults program.

Further information can be obtained at www.cdc.gov/meningococcal 01/2022
MEDICAL RECORD RELEASE FORM

To be completed and signed by student

I hereby give my authorization to the New York Medical College Health Services to release my records required for any future rotations at hospitals and clinical sites during my education here at NYMC. In the case of incomplete health requirements, the Deans and other administrative personnel will be informed of the specific missing requirements.

I understand that in order to be a student on rotation in medical institutions, it is mandated by New York State Law that each hospital has on file a copy of my records in order to show proof of proper immunizations, tuberculosis screening, and other health requirements.

Print Name: ____________________________________________

Signature: ______________________________ Date: ______________

01/03/2022
Overview of Services

Mental Health Services
Teladoc-Counseling and psychiatric evaluation and treatment.
Teladoc.com
Available 7 days a week, 7:00AM to 9:00PM Local time
1-800-835-2362

NYMC Clinicians (in-person and tele-visit)
- All services are available via telehealth and in-person, by appointment only
- Monday-Friday 9AM to 5PM

Email: SMHW@nymc.edu
Confidential Email: NYMC-SMHWConnect@nymc.edu (Only seen by our clinicians)

When emailing please include the following:
- Full name
- School
- Email address (must be NYMC or TCDM email)
- Reason for contacting to schedule an appointment
- Ideal day/time of appointment (please provide several)
- “I would like to prioritize_____”

24/7 Support Line – NYMC Health Advocate-1-(855) 384-1800.
Available 24 hours a day, 7 days a week. They also offer community resources and referrals. Visit: Health Advocate Member

Interactive Screening Program (“ISP”)
Take an anonymous screening that then allows students to receive anonymous and confidential feedback and support from SMHW clinicians. NYMC Cares for You

Wellness Classes-Yoga and Meditation are offered twice a week. The classes are virtual and in person, from September- May. Visit our website for the schedule.

All services are free and confidential