NEW YORK MEDICAL COLLEGE
A MEMBER OF THE TOURO COLLEGE AND UNIVERISTY SYSTEM
HEALTH SERVICES
BASIC SCIENCES BUILDING VALHALLA, NEW YORK 10595
TEL 914-594-4234 FAX 914-594-4692 HEALTH_SERVICES@NYMC.EDU

TO: Touro College of Dental Medicine at NYMC,
Incoming First Year Students 2021

FROM: Ronnie Myers DDS, Dean, Touro College of Dental Medicine at NYMC

Marisa Montecalvo MD, Director, Health Services

DATE: January 04, 2021

RE: Health Service Requirements – Directions

Welcome! Attached you will find the Health requirements for students and all forms. Please CAREFULLY READ the instructions below and on the forms. Failure to receive your health clearance will result in an inability to take part in any course or clinical activity.

1. Schedule an appointment with your health care provider NOW. You may need blood tests and boosters that can take up to a few months to complete. All completed forms are due no later than **June 1, 2021.**

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

3. Send the completed packet by FAX to NYMC Health Services, 914-594-4692, or documents may be scanned into a PDF file and sent to Health_Services@nymc.edu. JPEG files are not accepted.

4. **Be sure your Touro email is activated because Health Services will correspond with you using that email.** You must first configure your account using the link and Touro number that was sent to you. Any issues with email activation: Call 914-594-2000 and have your Touro number ready.

5. Check your Touro email 3 business days after sending in any health forms to see your status. You will receive an email from Health_Services@nymc.edu. with either:
   - A Completed Health Requirements letter or
   - A Missing Requirements letter – If you are missing requirements, again review the Health Services correspondence after any additional document is sent.

6. Call Health Services 914-594-4234 if you do not receive a letter or have questions.

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Health Services Requirements for Students of:
Touro School of Dental Medicine, Doctorate of Physical Therapy and Speech and Language Pathology Programs.
Bring these forms to your physician.

All vaccines and laboratory test information MUST INCLUDE the vaccine administration record and the actual result from the laboratory. Print outs from a patient portal are not acceptable.

1. Medical History Questionnaire, and Physical Exam Form:	Pages 1-3: Completed by student Pages 4-6: Completed, dated and signed by Health Care Provider
2. Release of records: Form attached	To be signed and dated by student
3. Meningococcal Vaccine Response Form Form attached	Completed by student Attach vaccine records of any meningococcal vaccination received.
4. TB Screening within 3 months of orientation start date –	An interferon gamma release assay (IGRA, commercially known as QuantiFERON- TB) or a 2 step Tuberculin skin test (TST). The second TST is administered 1-3 weeks after the initial test. A Chest xray is required for any positive TST or IGRA; must be after the date of the positive TB screening test. The radiologist's CXR report must be provided.
5. Hepatitis B Immunity	Full series (3 doses) of HBV vaccine PLUS full HBV panel including HBV surface antibody, HBV surface Ag, and HBV core antibody. Non-immune students with a negative surface antibody are to receive an HBV booster vaccine. A repeat HBV surface Ab is to be done 30 days after the booster and can be sent in separately if needed.
6. Measles, Mumps, Rubella Immunity	Beginning on or after age one: 2 MMR (at least 28 days apart), or 2 measles, 1 mumps and 1 rubella vaccine AND quantitative titer for measles, mumps & rubella antibody. Vaccine records required
7. Varicella Immunity	Documentation of two varicella vaccines AND quantitative titer for varicella antibody. Vaccine records required.
8. Tetanus Diptheria Pertussis Vaccine	A Tetanus booster within ten years of school start date. One booster as an adult is to include acellular pertussis (Tdap).

Applicant: Last Name/ First Name: _____

New York Medical College

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HEALTH SERVICES

Medical History and Physical Exam

for Health Professional Student

Student (Check school/ Program)

____ NYMC School of Medicine

____ Touro School of Dental Medicine at New York Medical College

NYMC Graduate School of Basic Medical Sciences

_____ Clinical Laboratory Sciences Program

NYMC School of Health Sciences and Practice

____ Speech and Language Pathology _____ Doctor of Physical Therapy

OFFICE USE ONLY: Date Received: _____

Applicant: Last Name/ First Name: _____

Student Section:

Date of Birth: _____ Sex (M/F): _____ E-Mail address:_____

Local Address:_____City:_____State:_____Zip:_____

Cell#: (____) _____ Home#: (____) _____

Physician's Name:_____ Physician Location (City, State): _____

Physician's Phone: (____) _____ Health Insurance Co: _____

Policy ID#:_____ Policy Group#: _____ Policy Rx #:_____

Policy Holder Name: _____ Policy Holder DOB: _____

Relationship to applicant: _____ (indicate if ***self***)

Emergency Contact: _____Relationship_____

Home phone #_____ Cell phone #_____Work phone# _____

PAST MEDICAL HISTORY: (Circle *none* if applicable)

Surgeries: (List year, procedure): _____ None

Hospitalizations: (List year, reason): _____ None

Active acute or chronic medical conditions: (Indicate illness & specify if ongoing):
_____ None

History of mental health condition? (Specify and indicate if in care**):**
_____ None

Please note, that NYMC offers Mental Health support services that may be of interest to you.

Current medications: _____ None

Allergies to medications, food or other substances: _____ None

FAMILY HISTORY: List disease and relationship: (i.e.: parent, sibling, maternal/paternal grandparent)

_____ None

Applicant: Last Name/ First Name: _____

PERSONAL and SOCIAL HISTORY:

Have you lived outside the U.S. for more than one month? (circle) Yes / No

If yes, specify country, when and duration: _____

Have you received BCG vaccine to prevent Tuberculosis? (circle) Yes / No

Have you or do you smoke/ vape? (circle) Yes / No

If Yes: specify amount and duration: _____

Do you feel that you are habitually using any drugs or alcohol? (circle) Yes / No

If Yes, Please specify: _____

REVIEW OF SYSTEMS:

Please indicate if you have had any of the conditions related to the areas below:

General: weight gain / weight loss	GI: constipation, diarrhea, rectal bleeding, stomach pains, hepatitis, other
Skin: rashes / other changes	GU: blood in urine, testicular lumps, other
HEENT: head injury / hearing disorder	GYN: abnormal menses, other
Neck: swollen glands, thyroid disorder	Blood or Immune disorder: specify:
Lungs: wheezing, infections, other	Neuro: headaches, seizures, vision disorder
Cardiac: high blood pressure, cardiac disorder	Skeletal: Joint pain, back problems, other:
Endocrine: diabetes, thyroid disorder, other	Psychiatric: Anxiety, Sleep problems, mood swings, depression

Applicant Signature: _____

Applicant: Last Name/ First Name: _____

HEALTH CARE PROFESSIONAL SECTION:

TUBERCULOSIS RISK ASSESSMENT: Must be Completed by Health Care Professional for all Students in accordance with New York State Department of Health guidance

Country of Birth of the Patient: _____

History of temporary or permanent 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, and countries in Western or Northern Europe):

No _____ Yes: _____

If Yes: Specify Country: _____ Duration of Time patient lived there: _____

When did the patient live in that country: _____

Did the patient receive BCG vaccination? No _____ Yes _____

Is the patient receiving any immune suppressive therapy or planned immune suppression No _____ Yes _____

If yes: Medication(s) or disease: _____

Duration of immune suppression and when treatment received: _____

Has the patient had close contact with anyone with TB disease? No _____ Yes_____

If yes: Specify contact and when it occurred: _____

Has the patient ever had a positive tuberculin skin test (TST) or IGRA* or evidence of TB: No ____ Yes ____

If yes: Specify test result: _____ (provide mm for TST) Test Date: _____
For IGRA, provide lab report of prior positive test

Date of CXR after positive TST or IGRA: _____ Result: _____

Student must provide an x ray report of CXR performed after date of positive TST/ IGRA

Has the patient ever been treated for latent TB or active TB: No _____ Yes_____

If Yes: Specify Medications received, duration, and dates received: _____

_____

*IGRA: Interferon Gamma Release Assay; commercial tests are referred to as Quantiferon/ Quantiferon Gold

Applicant: Last Name/ First Name: _____

TUBERCULOSIS SYMPTOM SURVEY for any Person with History of Latent or Active TB:

Check here if *not* applicable ☐ **If applicable, answer questions below:**

Does the patient have:

Persistent cough > 2 weeks: No _____ Yes_____

Cough producing phlegm or blood: No _____ Yes_____

Enlarged lymph nodes in the neck or upper chest: No _____ Yes_____

Unexplained fever or night sweats or chills for longer than 2 weeks? No _____ Yes_____

Unexplained weight loss of >= 5 lbs: No _____ Yes_____

BASELINE TUBERCULOSIS SCREENING for Students with NO History of Latent or Active TB:
Must be done within 3 months of day 1 of orientation

Done by either performing and IGRA or a 2 step TST. The 2nd TST must be administered 1-3 weeks after the initial test. A second test is not needed if the student can provide written documentation of a negative TST during the previous 12 months.

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: ___/___/_____

For negative TST:

Date of 2nd TST: ___/___/_____ or provide documentation of TST within past 12 months:

Date of TST within the past 12 months: Date placed: __/__/____ Date read:__/__/____

TST Result (Positive / negative) and mm: _____ _____mm

Applicant: Last Name/ First Name: _____

PHYSICAL EXAMINATION:

Date of Exam: _____/_____/_____

Height: _____Weight:_____Temperature:_____Pulse:_____Blood Pressure:_____

SKIN:	**LYMPHATIC:**
HEENT & NECK:	**ABDOMEN:**
LUNGS:	**EXTREMITIES:**
HEART:	**MUSCULOSKELETAL:**
BREASTS / TESTICLE(S):	**NEUROLOGIC:**

HEALTH PROVIDER ASSESSMENT: Please indicate below:

_____ 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 health condition(s) for which the **continuation of care** is required: Please provide a complete description of the care required:

_____

_____

Except as noted above, the applicant is in good physical and mental health and has no problem that might interfere with their ability to perform professional studies / new position.

_____ _____

Health Care Provider (Print Name) **State and License Number**

_____ _____ _____

Health Care Provider's Signature **Date** **Telephone 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, Menveo) 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 meningiditis.* 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 caries 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 01/2019

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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: _____