TO:    School of Health Sciences and Practice, Department of Physical Therapy  
        Incoming First Year Students 2020

FROM:  Marisa Montecalvo MD, Director, Health Services

DATE:  December 19, 2019

RE:     Health Requirements – Directions

Welcome! Attached you will find the Health Requirements and all the forms. These  
requirements are needed to ensure a safe and healthy environment. Failure to receive your  
health clearance will result in your inability to take part in any clinical activity.

Please CAREFULLY READ the instructions below and on the forms.

1. Schedule an appointment with your health care provider NOW. You may need blood  
tests and boosters that may take up to a few months to complete. All completed forms  
are due March 15, 2020.

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.

4. Be sure your NYMC email is activated.

5. Check your NYMC email 3 business days after sending in any forms to see your status.  
You will receive an email from Health_Services@nymc.edu. The letter will be either:

   • A Completed Health Requirements letter or
   • A Missing Requirements letter – If you are missing requirements, again  
   confirm receipt 3 days after the documents are requested from your physician.

6. Call Health Services 914-594-4234 if you do not receive a letter regarding your status or  
have questions.
Health Services Requirements for Students of:  
School of Medicine, Speech and Language Pathology, Doctorate of Physical Therapy,  
Clinical Laboratory Sciences  
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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
</table>
| 1. Medical History Questionnaire, and Physical Exam Form: 5 page form attached | Pages 1-3: Completed by student  
Pages 4-5: 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. Current TB Screening within 6 months of school start date | A tuberculin skin test (TST) is required. An interferon gamma release assay (QuantiFERON- TB) is ONLY accepted as a screening test if the student has a history of a positive TST that may be due to BCG receipt. |
| 5. CXR for persons with Positive TST or Positive Quantiferon | Chest Xray must be after the date of the positive TB screening test. Provide CXR report.         |
| 6. Hepatitis B Immunity                                | Full series (3 doses) of HBV vaccine PLUS a positive QUANTITATIVE HBV surface antibody (>10) or laboratory evidence of natural infection. 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. |
| 7. 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 OR positive antibody to measles, mumps & rubella. |
| 8. Varicella Immunity                                  | Documentation of two varicella vaccines OR positive antibody to varicella                        |
| 9. 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). |

12/17/2019
**New York Medical College**  
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

HEALTH SERVICES  
Medical History Questionnaire/  
And Physical Exam Form

<table>
<thead>
<tr>
<th>Student (Check school/ Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYMC School of Medicine</td>
</tr>
<tr>
<td>Touro School of Dental Medicine at New York Medical College</td>
</tr>
</tbody>
</table>

**NYMC Graduate School of Basic Medical Sciences**  
- Accelerated Master’s Program  
- PhD  
- Master’s Program  
- Clinical Laboratory Sciences

**NYMC School of Health Sciences and Practice**  
- Speech and Language Pathology  
- Doctor of Physical Therapy

OFFICE USE ONLY: Date Received: __________________
PERSONAL HISTORY INFORMATION:

Last Name ___________________________ First Name ___________________________

Date of Birth _______________________ Sex (M/F) _______ E-Mail address __________________________

Local Address ___________________________ City __________________________ State _______ Zip _______

Cell # (___) ___________________ Home# (___) ___________________ Country of Birth (Country) __________________________

Father’s Name ___________________________ Mother’s Name __________________________

Physician’s Name ___________________________ Physician Location (City, State): __________________________

Physician’s Phone (___) ______________________ Health Insurance Co. __________________________ Policy ID# __________________________

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

2 | P a g e
**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: _______________________________________

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**REVIEW OF SYSTEMS:**

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

<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 changes</td>
<td>GU: blood in urine, testicular lumps, other</td>
</tr>
<tr>
<td>HEENT: head injury / hearing disorder</td>
<td>GYN: abnormal menses, other</td>
</tr>
<tr>
<td>Neck: swollen glands, thyroid disorder</td>
<td>Blood or Immune disorder: specify:</td>
</tr>
<tr>
<td>Lungs: wheezing, infections, other</td>
<td>Neuro: headaches, seizures, vision disorder</td>
</tr>
<tr>
<td>Cardiac: high 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 problems, mood swings, depression</td>
</tr>
</tbody>
</table>

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Applicant Signature: ____________________________  Date: ____________________________
PHYSICAL EXAMINATION: To Be Completed by Health Care Provider

Date of Exam: _____/_____/_____
Height: _____ Weight: _____ Temperature: _____ Pulse: _____ Blood Pressure: _________

<table>
<thead>
<tr>
<th>SKIN:</th>
<th>LYMPHATIC:</th>
<th>HEENT &amp; NECK:</th>
<th>ABDOMEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUNGS:</td>
<td>EXTREMITIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART:</td>
<td>MUSCULOSKELETAL:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BREASTS / TESTICLE(S):</td>
<td>NEUROLOGIC:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TUBERCULOSIS (TB) SCREENING HISTORY:

Any past tuberculin skin test (TST) or blood test Quantiferon Gold® to detect TB? Yes /No
Date of Past TST: _____/_____/_____
Test Result: _____ (TST _____ mm)

Date of blood test Past Quantiferon Gold®: _____/_____/_____
Result: Positive / Negative (provide copy of lab)

If either positive, date of most recent chest x-ray: _____/_____/_____  
Include a copy of chest x-ray report

Was the patient treated for latent tuberculosis: If yes, medication taken: __________________________

Date Treatment started: _____/_____/_____ Number of months treated: __________________________
CURRENT TB SCREENING (Performed at Visit):

TST Lot # ____________________________  TST Lot # Expiration Date _____ / _____ / _____

Date of TST placed: _____ / _____ / _____  Test Result: _____ (TST _____ mm)

Date of TST read: _____ / _____ / _____  Result: Positive / Negative

If TST is now or previously positive, date of most recent chest x-ray: _____ / _____ / _____

(include a copy of chest x-ray report)

For students with a prior positive TST, if the positive TST may be due to receipt of BCG vaccination, please send an interferon gamma release assay test (QuantiFERON- TB) to sort help sort out whether the positive TST is BCG related. Please specify country where BCG vaccine was received: ____________________.

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
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: ___________________
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, Menvax) 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: Trumab, 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 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