TO: School of Health Sciences and Practice, Department of Physical Therapy
   Incoming First Year Students 2021

FROM: Marisa Montecalvo MD, Director, Health Services

DATE: January 12, 2021

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, 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.

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:
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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Medical History Questionnaire, and Physical Exam Form:</strong></td>
<td>Pages 1-3: Completed by student Pages 4-6: Completed, dated and signed by Health Care Provider</td>
</tr>
<tr>
<td><strong>2. Release of records:</strong></td>
<td>To be signed and dated by student</td>
</tr>
<tr>
<td><strong>3. Meningococcal Vaccine Response Form:</strong></td>
<td>Completed by student Attach vaccine records of any meningococcal vaccination received.</td>
</tr>
<tr>
<td><strong>4. TB Screening within 3 months of orientation start date –</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>5. Hepatitis B Immunity</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>6. Measles, Mumps, Rubella Immunity</strong></td>
<td>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 &amp; rubella antibody. Vaccine records required</td>
</tr>
<tr>
<td><strong>7. Varicella Immunity</strong></td>
<td>Documentation of two varicella vaccines AND quantitative titer for varicella antibody. Vaccine records required</td>
</tr>
<tr>
<td><strong>8. Tetanus Diptheria Pertussis Vaccine</strong></td>
<td>A Tetanus booster within ten years of school start date. One booster as an adult is to include acellular pertussis (Tdap).</td>
</tr>
</tbody>
</table>
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: _____________
**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
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:

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

Applicant Signature: ________________________________________________
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
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
**PHYSICAL EXAMINATION:**

Date of Exam: _____/_____/_____

Height: _______ Weight:________ Temperature:_______ Pulse:_________ Blood Pressure:____________

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

**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:

________________________________________________________________________________________

_____________________________             _______________________________
Health Care Provider (Print Name)                   State and License Number

_____________________________      ____________              _________________________________
Health Care Provider’s Signature                     Date                                Telephone Number

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.
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 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](http://www.cdc.gov/meningococcal) 01/2019
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: __________________

01/23/2019