Dear New Student,

Welcome to Columbia University Medical Center (CUMC). Here at the Student Health Service (SHS), we look forward to working with you to achieve optimal health and academic success. In order to accomplish those goals, we need your assistance in completing your preregistration requirements. This packet lists the required information you must provide in order to register for classes. The information is required for participation in the clinical programs listed above. Incomplete information will result in a delay in your ability to register for classes. If you have any questions, do not hesitate to contact us.

We look forward to welcoming you on campus, and to working with you during your time here.

Sincerely,
CUMC Student Health Service

IMPORTANT INFORMATION

DEADLINE DATES:
• Summer 2017 Enrollment: April 27, 2017
• Fall 2017 Enrollment: June 29, 2017
• Spring 2018 Enrollment: December 17, 2017

CONTACT INFORMATION

For questions:
• Email: shsregistration@cumc.columbia.edu
• SHS Website: cumc.columbia.edu/student-health

For submission of preregistration requirements:
• WebPortal: cuhs.studenthealthportal.com (preferred)
• Fax Number: 212-305-2176
• Mail*: (not recommended; use only if no other option available)
  FedEx Address: CUMC Student Health Service, 60 Haven Avenue, Lobby Level New York, NY 10032
  USPS Address: CUMC Student Health Service, 630 West 168th Street, Mailbox 77, New York, NY 10032

* Please allow additional processing time for all mail submissions.
Follow the steps below to understand the process for fulfilling and submitting documentation of your health and immunization requirements. These steps can also be found on the SHS website: cumc.columbia.edu/student-health/especially/new-students

**STEP 1: READ THIS NEW STUDENT PREREGISTRATION HEALTH REQUIREMENT LETTER**

Please read and understand the requirements and leave yourself enough time (*approximately two months prior to your deadline date, listed on front page*) to collect past medical information or obtain immunizations and titers. It may take time for past providers of care to send records to you, or you may need immunizations that must be spaced out by at least a month.

*For all titers, please submit the actual laboratory report for each titer.*

<table>
<thead>
<tr>
<th>REQUIRED TO SUBMIT</th>
<th>REQUIRED DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PHYSICAL EXAM</td>
<td>Physical Exam:</td>
</tr>
<tr>
<td></td>
<td>• Must be completed by a clinician (who is not a relative).</td>
</tr>
<tr>
<td></td>
<td>• Date of exam must be within twelve months of program start date.</td>
</tr>
<tr>
<td>□ HEALTH HISTORY</td>
<td>Health History:</td>
</tr>
<tr>
<td></td>
<td>• Must be entered online after you receive your Columbia UNI.</td>
</tr>
<tr>
<td></td>
<td>• Enter at cuhs.studenthealthportal.com.</td>
</tr>
<tr>
<td>□ MENINGITIS</td>
<td>Meningococcal Meningitis Response Form:</td>
</tr>
<tr>
<td></td>
<td>• Must be entered online after you receive your Columbia UNI.</td>
</tr>
<tr>
<td></td>
<td>• Enter at cuhs.studenthealthportal.com.</td>
</tr>
<tr>
<td></td>
<td>• Receipt of the vaccine is optional.</td>
</tr>
<tr>
<td></td>
<td>• Information on the vaccine is available at: cdc.gov/meningococcal/vaccine-info.html.</td>
</tr>
<tr>
<td>□ MEASLES (RUBEOLA), MUMPS, RUBELLA (MMR)</td>
<td>Two Doses of MMR Vaccine OR Two Doses of Measles, Two Doses of Mumps and One Dose of Rubella OR Serologic Proof of Immunity for Measles, Mumps and Rubella</td>
</tr>
<tr>
<td></td>
<td>• Submit dates of previous doses of vaccine or serologic proof of immunity.</td>
</tr>
<tr>
<td></td>
<td>• <strong>NOTE:</strong> Vaccine doses must be at least 28 days apart.</td>
</tr>
<tr>
<td>□ VARICELLA</td>
<td>Two Doses of Varicella Vaccine OR Positive Varicella IgG Antibody Titer (with history of chicken pox)</td>
</tr>
<tr>
<td></td>
<td>• If you have a negative or indeterminate titer, obtain two doses of vaccine at least 30 days apart.</td>
</tr>
<tr>
<td></td>
<td>• History of disease is not sufficient.</td>
</tr>
<tr>
<td>□ TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS</td>
<td>One-time Adult Dose of Tdap Vaccine:</td>
</tr>
<tr>
<td></td>
<td>• Tdap is required regardless of date of last tetanus shot.</td>
</tr>
<tr>
<td></td>
<td>• Td (tetanus/diptheria) boosters every 10 years thereafter.</td>
</tr>
<tr>
<td>□ POLIO VACCINE</td>
<td>Polio Vaccine:</td>
</tr>
<tr>
<td></td>
<td>• Date of most recent IPV (killed) or OPV (live) polio vaccine.</td>
</tr>
</tbody>
</table>
### Hepatitis B

**Three Doses of Hepatitis B vaccine AND Positive Quantitative Hepatitis B IgG Surface Antibody Titer:**
- Provide all three dates of vaccinations.
- Positive Hepatitis B surface antibody titer value and lab report.
- a Hepatitis B surface antigen.

**If you received vaccination and titer did not convert to positive:**
If you have completed the Hepatitis B series of three immunizations and your titer does not convert to reactive/positive (negative or equivocal), you must obtain and submit the date for a fourth dose of Hepatitis B. Also submit the date of the previous three immunizations and negative/non-reactive titer. If you have already received two full courses of Hepatitis B vaccination (six doses—two series of three shots) submit the dates of ALL doses of vaccine and negative titers.

**Note:** The Hepatitis B vaccination series requires three vaccinations given at minimum intervals of 0, 28 and 240 days (zero, one, and six months). Greater intervals are permissible. Do not restart a vaccination series; just pick up where you left off. Following the completion of the series, and at least four weeks after the last dose, a Hepatitis B Surface Antibody titer must be drawn to confirm immunity.

### Hepatitis C

**Hepatitis C Antibody – Date, Result and Lab Report**
- Hepatitis C antibody 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.

### Tuberculosis Screening

**NOTE:** A PPD skin test may NOT be placed in the 30 days after administration of a live virus vaccine (including MMR and varicella). PPDs placed in the 30 days after receipt of a live virus vaccine are invalid and must be repeated.

**Two-step PPD Skin Testing:**
- Two PPD (tuberculosis screening) skin tests administered 9-31 days apart, within six months of program start date.
- **Note:** Do not receive a TB skin test in the days following a live virus vaccine; the same day is permissible.

**OR**

**IGRA Blood Test (QuantiFERON or T-SPOT):**
- Documentation of a negative QuantiFERON Gold or T-SPOT test completed within six months of program start date.

**Question about BCG?** Students born outside of the U.S. who received BCG vaccine should follow the TB screening requirements as listed above. If you have had slight reactions to a PPD skin test in the past, it is recommended you opt for IGRA blood testing.
FOR PEOPLE WITH A POSITIVE SKIN TEST

For People with a POSITIVE Skin Test (Reading > 10 mm) History:

- **No INH therapy or therapy taken for < six months:** Submit date and mm reading of your positive PPD and report of a chest x-ray completed after positive test.  
  
  **Or**
  
- **INH therapy taken for six months or greater:** Submit date and mm reading of your positive PPD and report of a chest x-ray taken at time of conversion along with latent TB infection treatment.

STEP 2: GATHER PAST DOCUMENTATION OF IMMUNIZATIONS, TITERS, AND PPD TESTING

The Immunization Form found at the end of this packet contains a place for your clinician to record data for all the requirements listed above in this letter. You will need to collect records of past immunizations, titers, and TB testing as well as obtain healthcare services to address missing requirements. If you received these services outside the U.S., please leave extra time for receiving the documentation (in English). You MUST submit a copy of titer reports from the laboratory.

**Keep a copy of all documentation for your personal records.**

STEP 3: MAKE AN APPOINTMENT TO GET A PHYSICAL EXAM, MISSING IMMUNIZATIONS, TITERS, AND TUBERCULOSIS SCREENING

You will most likely need to obtain some healthcare services to complete this process. You should have copies of all past immunizations, titers, and tuberculosis screening to take to your provider. You will need a provider to complete and sign the Immunization Form validating the dates on which you received physical/immunizations/titers/tuberculosis screening to meet the full battery of healthcare requirements.

Bring a copy of this letter with you to your appointment to outline the requirements to your provider. Immunization and TB screening requirements are more stringent for healthcare workers than the general population and your provider may request details on the requirements.

**VERY IMPORTANT - Keep a copy of your past records for your own files!** You may be asked to present them again to certain rotations or work sites that will only accept original documentation to meet certain healthcare screening processes. This includes any titer results from the lab.

STEP 4: ENTER YOUR HEALTH HISTORY AND MENINGOCOCCAL RESPONSE ONLINE

Once your Columbia UNI has been assigned, you can access the secure Web Portal to enter your health history and meningococcal response at cuhs.studenthealthportal.com. You will need to create a new account using your UNI. Please use a personal email for registration if your Columbia email account has not yet been activated. You will need to upload your meningococcal waiver to the following two sites:

- [Columbia University Student Services Online (SSOL)]
- [CUMC Student Health Web Portal]

Both are required for registration clearance.

STEP 5: SUBMIT YOUR COMPLETED IMMUNIZATION FORM AND REQUIRED ATTACHMENTS PRIOR TO DEADLINE DATE

Submit only when complete immunization form and required attachments are available and after your Columbia UNI has been assigned.
Deadline Dates:

- Summer 2017 Enrollment: Requirements must be received by **April 27, 2017**
- Fall 2017 Enrollment: Requirements must be received by **June 29, 2017**
- Spring 2018 Enrollment: Requirements must be received by **December 17, 2017**

Make a copy of the signed form and all attachments for your records, and submit to SHS. Forms only need to be submitted via one of the following methods:

- **Web Portal (preferred):** Please upload your completed immunization form and required attachments via the secure Web Portal: [cuhs.studenthealthportal.com](http://cuhs.studenthealthportal.com). Once you have logged in, select “document upload.” In the “document type” menu, select “immunization form.” Use the browse button to locate the PDF or TIFF file (JPEG files will not be accepted), and select “save.”

If you are unable to submit completed forms via the Web Portal:

- **Fax:** 212-305-2176
- **U.S. Postal Service Address:** CUMC Student Health Service, 630 West 168th Street, Mailbox 77, New York, NY 10032
- **FedEx Address:** (accepted 8AM - 5PM): CUMC Student Health Service, 60 Haven Avenue, Lobby Level, New York, NY 10032

*All information is treated confidentially and is considered to be part of your medical record. It will be stored in a secure, confidential electronic medical record system accessible only to Student Health Service staff. This information is collected solely for the purposes of assessing and reducing your risk of acquiring a communicable disease.*

**STEP 6: TO VERIFY YOUR INFORMATION HAS BEEN PROCESSED, CHECK YOUR IMMUNIZATION RECORD ON THE WEB PORTAL AND YOUR SSOL ACCOUNT**

Please wait until three weeks after your deadline date to verify the status of your submission. Log into your Web Portal at [cuhs.studenthealthportal.com](http://cuhs.studenthealthportal.com), click on “My Profile” and select “Immunization History”. If all requirements have been met, you will see “Cleared for Registration”. If some requirements are still pending, you will see “Preregistration Incomplete”. In that case, check your messages for information on the pending requirements. If neither entry is present, your submission has either not been received or reviewed.

You can also check your “Health Hold” status online in your Student Services On-Line (SSOL) account. CUMC places a hold on your student account until your preregistration requirements are met. SSOL may state that the hold is due to a missing MMR requirement; please ensure that ALL CUMC-specific health requirements are met. This hold blocks you from registering for class or being eligible for student health insurance. The hold will be released after your healthcare requirements are submitted and verified—this occurs within 48 hours of the “Cleared for Registration” status being visible on your immunization record. If at this time you have submitted all your information and you continue to see a health hold, please email us at [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu).
OTHER QUESTIONS TO CONSIDER

What happens if I do not submit my completed documentation by the time I try to register?
You CANNOT register unless all requirements are met.

What if I have a medical condition that interferes with my ability to meet the requirements?
If you have a medical condition that is of concern related to the requirements, please email us at shsregistration@cumc.columbia.edu.

Will any of my TB or immunization data impact my admissions status?
No! This data will not be reviewed by your school. SHS only reports if you are in compliance or out of compliance.

What if I did not get my form signed or do not have somewhere to go for services?
SHS can perform this service for you for a fee if you are in New York City. Be careful not to wait, as the process can take some time. An administrative fee of $95 will be charged to students completing any preregistration requirements at SHS, with additional fees charged for each service rendered (immunizations and titers). We do not accept any type of insurance for these services, and full payment is due at the time of service (via cash, check or credit card). See the complete list on the SHS website: cumc.columbia.edu/student-health/espe-cially/new-students/health-requirement-fee-schedule. Appointments can be scheduled by calling 212-305-3400, and selecting prompt 1.

What should I do if I do not have my completed preregistration information?
WAIT! Sending partial information delays the clearance process. Please submit only when complete immunization form and required attachments are available.

Who do I contact for questions about preregistration requirements?
For questions concerning preregistration requirements, email shsregistration@cumc.columbia.edu.
For questions concerning insurance, email shsinsurance@cumc.columbia.edu.

Thank you! We look forward to serving as your healthcare partner while you are at CUMC!
Directions to Bard-Haven Tower 1 Locations

- Enter Bard-Haven Tower 1 entrance, located at 60 Haven Avenue.
- Turn right after passing the Security Desk.
- Proceed down the hallway; Suite B234 will be on the left.
- Continue down the corridor toward the big open space and turn left, then right to the elevators to access the 1st floor (Suite 1D) and 3rd floor (Suites 3D and 3E).

Directions to Bard Hall Locations

- Enter Bard Hall main entrance, located at 50 Haven Avenue.
- Turn right at the security desk, then follow the second hallway to the left (across from the Office of Housing Services); Suites 101 and 102 will be on the right.
- Turn left at the security desk; Suite 107 will be on the left.
This form must be completed by an MD, NP, or PA who is not a relative. Please ensure form is complete and has a health care provider signature. Attach physical exam, immunization records, and copies of all titers, antigens, and x-rays. All reports must be submitted in English. Failure to do so will result in an incomplete application.

Name: ____________________________________  UNI: ____________________

Date of Birth: ____________________  CUMC School: ____________________  □ Full-time  □ Part-time

Contact Telephone: (______) - _________________________  □ Male  □ Female  □ Transgender

### PHYSICAL EXAM

Completed form *(included at the end of this packet)* OR copy of physical exam performed by your provider.

### MEASLES (RUBEOLA), MUMPS, RUBELLA (MMR)

- Items **A, B, or C** on right will meet requirements.

#### A. MMR Immunizations (after age 1 and at least 28 days apart)

- MMR Dose 1 date: _______/_____/_____
- MMR Dose 2 date: _______/_____/_____

#### OR

#### B. Positive MMR IgG Antibody titers

- Measles (Rubeola) titer date: _______/_____/_____  Result: ____________  □ Copy Attached
- Mumps titer date: _______/_____/_____  Result: ____________  □ Copy Attached
- Rubella titer date: _______/_____/_____  Result: ____________  □ Copy Attached

#### OR

#### C. Measles, Mumps and Rubella Immunizations (after age 1 and at least 28 days apart)

- Measles Dose 1 date: _____/_____/_____  Measles Dose 2 date: _____/_____/_____  
- Mumps Dose 1 date: _____/_____/_____  Mumps Dose 2 date: _____/_____/_____  
- Rubella Dose 1 date: _____/_____/_____  

### POLIO

**Polio vaccine (most recent)**

- Dose date: _______/_____/_____  □ IPV  □ OPV *(check one)*

### TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS*

**Tdap vaccine (required)**

- Dose date: _____/_____/_____  
- *One time adult dose of Tdap vaccine is required regardless of date of last tetanus shot. Td (tetanus/diphtheria) boosters every 10 years thereafter.*
- Td vaccine dose date: _____/_____/_____ (if more than 10 years since last Tdap)

### VARICELLA

*Please check titer first before receiving vaccine. If you have a negative or indeterminate titer, obtain two doses of vaccine at least 30 days apart. History of disease is not sufficient.

**Positive Varicella IgG Antibody titer**

- Titer date: _______/_____/_____  Result: ________________  □ Copy Attached

**OR**

**Varicella Immunizations (two doses required)**

- Dose 1 date: _____/_____/_____  Dose 2 date: _____/_____/_____
HEPATITIS B

- Items **A or B** on right will meet requirements.

### A. Three doses of Hepatitis B vaccine AND Positive Hepatitis B IgG surface antibody titer AND Hepatitis B Antigen titer:

- **Dose 1 date:** _______ /_______ /_______
- **Dose 2 date:** _______ /_______ /_______
- **Dose 3 date:** _______ /_______ /_______

**Hepatitis B Surface Antibody Quantitative titer:**

- **Titer date:** _______ /_______ /_______  Result: ______________  □ Copy Attached

**Hepatitis B Surface Antigen titer:**

- **Titer date:** _______ /_______ /_______  Result: ______________  □ Copy Attached

**If you received vaccination and titer did not convert to positive:**

If you have completed the Hepatitis B series of three immunizations and your titer does not convert to reactive/positive (negative or equivocal), you must obtain and submit the date for a fourth dose of Hepatitis B. Also submit the date of the previous three immunizations and negative/non-reactive titer. If you have already received two full courses of Hepatitis B vaccination (six doses—two series of three shots) submit the dates of ALL doses of vaccine and negative titers.

- **Dose 4 date:** _______ /_______ /_______
- **Dose 5 date:** _______ /_______ /_______
- **Dose 6 date:** _______ /_______ /_______

**Hepatitis B Surface Antibody Quantitative titer (required if above series complete):**

- **Titer date:** _______ /_______ /_______  Result: ______________  □ Copy Attached

**OR**

### B. History of Hepatitis B infection:

Core antibody & surface antigen titer results (these titers submitted in instance of prior infection). Only positive titers reflect history of past disease.

If BOTH of these titers are negative you should be immunized and receive the surface antibody titer.

**Hepatitis B Core Antibody Quantitative titer (within six months of start date):**

- **Titer date:** _______ /_______ /_______  Result: ______________  □ Copy Attached

**Hepatitis B Surface Antigen titer (within six months of program start date):**

- **Titer date:** _______ /_______ /_______  Result: ______________  □ Copy Attached

HEPATITIS C

### Hepatitis C Antibody (within six months of program start date)

**Hepatitis C IgG titer:**

- **Titer date:** _______ /_______ /_______  Result: ______________  □ Copy Attached

**Hepatitis C Quantitative RNA (only if IgG positive):**

- **Date:** _______ /_______ /_______  Result: ______________  □ Copy Attached
**TB SCREENING**

- Please complete one TB section only.
- Testing is required regardless of prior BCG status.
- Placement and read date documentation needed within 48-72 hours

### NEGATIVE TB SCREEN

- Please submit data for **either A or B**. Either of the options will meet the requirement.

  **NOTE:** A PPD skin test may NOT be placed in the 30 days after administration of a live virus vaccine to be considered valid. Live virus vaccines include measles, mumps, rubella, and varicella.

#### A. PPD Skin Test:

**Two-step PPD skin testing:** Two PPD (tuberculosis skin testing) skin tests administered 9-31 days apart within six months of program start date

- PPD test 1 placement ____ /____ /___ Reading ___ /____ /___ reading _____ mm
  - □ Result Interpretation Negative □ Result Interpretation Positive

- PPD test 2 placement ____ /____ /___ Reading ___ /____ /___ reading _____ mm
  - □ Result Interpretation Negative □ Result Interpretation Positive

- **NOTE:** A PPD skin test may NOT be placed in the 30 days after administration of a live virus vaccine to be considered valid. Live virus vaccines include measles, mumps, rubella, and varicella.

- **Question about BCG?** Students born outside the U.S. who received BCG vaccine should follow the TB screening requirements as listed above. **If you have had slight reactions to a PPD skin test in the past, it is recommended you opt for IGRA blood testing.**

  **OR**

#### B. IGRA Blood Test (QuantiFERON or T-SPOT testing):

Documentation of a negative test reported within six months of program start date.

- Test date _____ /_____ /____ (only a negative test meets requirement)
- Result ___________ □ Copy Attached

### POSITIVE TB SCREEN

(Recent or past)

- History of latent TB, positive skin test or positive blood test complete **C**.

- History of active TB, complete **D**

#### C. POSITIVE skin test (reading > 10 mm):

- PPD read date _____ /_____ /___ Reading ___ mm

  **OR**

- Positive IGRA Blood Test (QuantiFERON or T-SPOT testing):
  - Test date _____ /_____ /___
  - Result ___________ □ Copy Attached

- **Chest X-ray Report (required):**
  - X-ray results: □ normal □ abnormal Date: _____ /_____ /____ □ Copy Attached

- **Prophylactic medications for latent TB taken:**
  - □ Yes □ No
  - Date started: _____ /_____ /___ Date ended: _____ /_____ /___
  - Length of treatment ______ months

### TB SCREENING QUESTIONS: REQUIRED

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever received BCG?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ yes □ no if yes: Year ___________ Country __________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you traveled and/or lived overseas in the past year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ yes □ no if yes: Countries __________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you worked in a prison or homeless shelter in the past year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you entered a TB isolation room in the past year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had exposure to a known case of TB in the past year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**TB SCREENING QUESTIONS: CONTINUED**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive sweating at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent coughing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing up blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoarseness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent fever</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OR**

D. History of Active TB:

Date of diagnosis: _____ / _____ / _____  Date treatment completed: _____ / _____ / _____

Chest X-ray Report (required):

X-ray results: □ normal □ abnormal  Date: _____ / _____ / _____  □ Copy Attached

I certify that I performed a physical exam on the above named student on ______________________ (date). He/she is in good health and is free of contagious disease. To the best of my knowledge, he/she is free from any health impairment which is of potential risk to patients or which might 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.

Provider’s signature _______________________________________ Date_________________________

Provider’s name printed___________________________________ License number________________

Clinician/Practice stamp
STUDENT HEALTH HISTORY FORM

This form must be completed by an MD, NP, or PA who is not a relative.

Name: ____________________________________ UNI: __________________________

Last     First     Middle Initial

Date of Birth: _____ / _____ / ______  CUMC School: ____________________ □ Part-time □ Full-time

Contact Telephone: (______) - ________________________ □ Male     □ Female     □ Transgender

HEALTH HISTORY

Any significant findings in the student’s past health history? □ yes  □ no
If yes, please specify: ____________________________________________________________
________________________________________________________________________________

Tobacco use: ________________________________________________________________

Alcohol use (drinks/week): ___________________________________________________

Other drug use: ______________________________________________________________

Any allergies to medications? □ yes  □ no
If yes, please specify: ________________________________________________________

Any latex or other non-medication allergies? □ yes  □ no
If yes, please specify: ________________________________________________________

Please list current medications and doses, including contraceptives, non-prescription medications, vitamins, and supplements:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
PHYSICAL EXAM FORM

Date of exam must be within 12 months of school deadline date

Visual Acuity: OD ___________ OS ___________ Correction? □ yes □ no

Height (inches) _______ Weight (pounds) _______ BP ___________ Pulse ___________

Normal Abnormal Not Done If abnormal, please explain

General appearance □ □ □ __________________________________________

Head □ □ □ __________________________________________

Eyes □ □ □ __________________________________________

Ears, Nose, Throat □ □ □ __________________________________________

Neck □ □ □ __________________________________________

Lymph Nodes □ □ □ __________________________________________

Breasts □ □ □ __________________________________________

Heart □ □ □ __________________________________________

Lungs □ □ □ __________________________________________

Abdomen □ □ □ __________________________________________

Pelvic Exam □ □ □ __________________________________________

GU Exam □ □ □ __________________________________________

Rectal Exam □ □ □ __________________________________________

Extremities □ □ □ __________________________________________

Neurological Exam □ □ □ __________________________________________

I certify that _________________________________ is in good health and free of contagious disease. □ yes □ no

Does this student require ongoing medical care? □ yes □ no

Specify __________________________________________________________________________________________

________________________________________________________________________________________________

Provider’s signature _______________________________________ Date of Exam ______ /______ /______

Physician, Nurse Practitioner, Physician’s Assistant, or RN

Telephone number ___________________________ License number________________

Clinician/Practice stamp

NAME _________________________ UNI _________________________