Dear New Student,

Welcome to Columbia University Medical Center (CUMC). Here at Student Health Service (SHS), we look forward to working with you to achieve optimal health and academic success.

This packet lists the required information you must provide in order to register for classes in the clinical programs listed above. **Incomplete information will prevent registration for classes.** If you have any questions, do not hesitate to contact us at shsregistration@cumc.columbia.edu

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

Sincerely,
CUMC Student Health Service

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**How to Submit Your Preregistration Requirements**

**Deadline Dates:**
- Summer 2018 Enrollment: **April 27, 2018**
- Fall 2018 Enrollment: **June 29, 2018**
- Spring 2019 Enrollment: **December 17, 2018**

We **strongly recommend** you submit your preregistration requirements via our secure Web Portal.

- Upload your immunization records or completed immunization form and required attachments via our secure Web Portal: cuhs.studenthealthportal.com.
- Once logged in, select “Document Upload.”
- In the “Document Type” menu, select “Immunization Form” or “Preregistration Forms.”
- Use the browse button to locate the PDF or TIFF files (JPEG files will not be accepted), and select “Save.”

**If you are unable to submit preregistration documents via our Web Portal, please allow an additional three weeks for processing via the following methods:**
- **Email:** shsregistration@cumc.columbia.edu
- **Fax Number:** 212-305-2176
- **Postal Mail is strongly discouraged. Be sure to keep original copies if mailed:**
  - U.S. Postal Address: CUMC Student Health Service, 630 West 168th Street, Mailbox 77, New York, NY 10032
  - FedEx Address: CUMC Student Health Service, 60 Haven Avenue, Lobby Level New York, NY 10032
    (accepted 8 a.m.-5 p.m.)
CUMC PREREGISTRATION CLINICAL REQUIREMENT CHECK LIST

Please read through the requirement check list and leave yourself enough time (approximately two months prior to your deadline date, listed on front page) to collect medical information and obtain immunizations and titers. It may take time for past providers to send records to you, or you may need immunizations that must be spaced at least a month apart. Please submit the actual laboratory report for each titer.

STEP 1: ENTER YOUR HEALTH HISTORY AND MENINGOCOCCAL RESPONSE ONLINE

Once your Columbia UNI has been assigned, you can access our secure online Web Portal to enter your health history and meningococcal response. You will need to create a new account using your UNI. Please activate and use your Columbia email account or use a personal email for registration if your Columbia email account has not yet been activated.

□ HEALTH HISTORY
  • Must be completed online after you receive your Columbia UNI.
  • Enter at cuhs.studenthealthportal.com.

□ MENINGOCOCCAL MENINGITIS RESPONSE FORM
  • Must be completed online, after you receive your Columbia UNI, at the following two sites.
    • cuhs.studenthealthportal.com.
    • Columbia University Student Services Online (SSOL)
  • Receipt of the vaccine is optional.
  • Information on the vaccine is available at: cdc.gov/meningococcal/vaccine-info.html.

STEP 2: GATHER IMMUNIZATION RECORDS AND SCHEDULE A PHYSICAL EXAM APPOINTMENT WITH YOUR HEALTH CARE PROVIDER.

The Immunization and Physical Exam forms can be found at the end of these instructions. You will need to visit a medical provider to conduct your physical exam and complete the immunization form. Be sure to take copies of all past immunizations, titers, and tuberculosis screening to your provider at the time of your physical exam. Bring the CUMC Physical Exam and CUMC Immunization forms to your appointment to outline clinical requirements for 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. Have your provider complete and sign the Immunization Form validating the dates on which you received physical exam, immunizations, titers, and tuberculosis screening to meet CUMC healthcare requirements. If you receive services outside the U.S., please submit documents in English. You MUST submit copies of titer reports from the laboratory.

VERY IMPORTANT - Keep a copy of your past records for your own files!
<table>
<thead>
<tr>
<th>REQUIRED TO SUBMIT</th>
<th>REQUIRED DATA</th>
</tr>
</thead>
</table>
| **□ PHYSICAL EXAM** | Physical Exam within 12 months of program start date  
  • Must be completed by a clinician (who is not a relative). |
| **□ MMR REQUIREMENT**  
  *(NYS Public Health Law)* | 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  
  • Must submit lab reports. |
| **□ VARICELLA** | Two Doses of Varicella Vaccine OR Positive Varicella IgG Antibody Titer  
  • If you have a negative or indeterminate titer, obtain two doses of vaccine at least 30 days apart. |
| **□ TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS** | One-time Dose of Tdap Vaccine  
  • Tdap is required regardless of date of last tetanus shot.  
  • Td (tetanus/diphtheria) boosters every 10 years thereafter. |
| **□ HEPATITIS B** | Three Doses of Hepatitis B vaccine  
  **AND**  
  Positive Quantitative Hepatitis B IgG Surface Antibody Titer (HBsAb) at least one month after your last dose of Hepatitis B vaccine  
  **AND**  
  HEPATITIS B SURFACE ANTIGEN  
  *If you have completed the Hepatitis B vaccine series and your titer did not convert to positive: you must obtain and submit the date for a fourth dose. You must submit dates of all Hepatitis B vaccines received along with negative titer results.  
  *If you have a history of Hepatitis B infection, submit Core antibody and antigen titers. |
| **□ HEPATITIS C** | Hepatitis C Antibody – Lab Report Required  
  • Hepatitis C antibody within six months of program start date.  
  • If positive, a quantitative hepatitis C RNA test is required within six months of program start date. |
| **□ TUBERCULOSIS SCREENING** | Two-step PPD Skin Testing:  
  • Two PPD (tuberculosis screening) skin tests administered one to three weeks apart, within six months of program start date.  
  **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. |
| **□ FOR PEOPLE WITH A POSITIVE SKIN TEST OR A POSITIVE IGRA BLOOD 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 3: 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.

**See front page of this booklet for important deadline dates and submission instructions**

STEP 4: CHECK YOUR IMMUNIZATION RECORD ON THE WEB PORTAL AND YOUR SSOL ACCOUNT TO VERIFY YOUR INFORMATION HAS BEEN PROCESSED

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, 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.

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 related to the requirements listed above, 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 compliance or non-compliance with the requirements.

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/especially/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!
IMMUNIZATION FORM: CLINICAL PROGRAMS

This form must be completed by an MD/DO, NP, or PA who is not a relative. 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 failure to register for your program.

Name: ______________________________________  UNI: ____________________________
Last First Middle Initial

Date of Birth: ________________  CUMC School: ____________________________
□ Full-time  □ Part-time

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

<table>
<thead>
<tr>
<th>PHYSICAL EXAM</th>
<th>Completed form (included at the end of this packet) OR copy of physical exam performed by your provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASLES (RUBEOLA), MUMPS, RUBELLA (MMR)</td>
<td>Items A, B, or C on right will meet requirements.</td>
</tr>
</tbody>
</table>
| A. MMR Immunizations (On or after first birthday and at least 28 days apart) | MMR Dose 1 date: _______ /_______ /_______  
MMR Dose 2 date: _______ /_______ /_______ |
| OR |  |
| B. Positive MMR IgG Antibody titers (lab reports required) | 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 (On or after first birthday 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: _____ /_____ /_____ |

<table>
<thead>
<tr>
<th>POLIO</th>
<th>Polio vaccine (most recent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose date: _______ /_______ /_______</td>
<td></td>
</tr>
<tr>
<td>□ IPV  □ OPV (check one)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS*</th>
<th>Tdap vaccine (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose date: _______ /_______ /_______</td>
<td></td>
</tr>
<tr>
<td>*One time dose of Tdap vaccine is required regardless of date of last tetanus shot. Td (tetanus/diphtheria) boosters every 10 years thereafter.</td>
<td></td>
</tr>
<tr>
<td>Td vaccine dose date: _______ /_______ /_______ (if more than 10 years since last Tdap)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VARICELLA</th>
<th>Positive Varicella IgG Antibody titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titer date _______ /_______ /_______  Result: ______________  □ Copy Attached</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>*Varicella Immunizations (two doses required at least 28 days apart)</td>
<td>Dose 1 date: _______ /_______ /_______  Dose 2 date: _______ /_______ /_______</td>
</tr>
</tbody>
</table>
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:** (Lab report required)

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

**Hepatitis B Surface Antigen titer:** (Lab report required)

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 is negative/equivocal one to two months after your last vaccine, 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 and 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 check the surface antibody titer one to two months after last dose of vaccine.

**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** (Lab report required)

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

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

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

- Please complete one TB screening only.
- Testing is required regardless of prior BCG status.
- For Tuberculin Skin Testing (TST) placement and read date documentation should not exceed 48-72 hours.

### NEGATIVE TB SCREEN

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

  **NOTE:** A TST 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.

<table>
<thead>
<tr>
<th>A. Two-step Tuberculin Skin Test (TST):</th>
<th>Two TSTs administered one to two weeks apart within six months of program start date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TST test 1 placement ____ / ____ / ___</td>
<td>Reading ____ / ____ / ____ reading _____ mm</td>
</tr>
<tr>
<td>□ Result Interpretation Negative □ Result Interpretation Positive</td>
<td></td>
</tr>
<tr>
<td>TST test 2 placement ____ / ____ / ___</td>
<td>Reading ____ / ____ / ____ reading _____ mm</td>
</tr>
<tr>
<td>□ Result Interpretation Negative □ Result Interpretation Positive</td>
<td></td>
</tr>
</tbody>
</table>

**Question about BCG?** Students born outside the U.S. who received BCG vaccine should follow the TB screening requirements as listed above.

  **OR**

<table>
<thead>
<tr>
<th>B. IGRA Blood Test (QuantiFERON or T-SPOT testing):</th>
<th>Documentation of a negative test reported within six months of program start date (lab report required).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test date _____ / _____ / ____ (only a negative test meets requirement)</td>
<td></td>
</tr>
<tr>
<td>Result ___________ □ Copy Attached</td>
<td></td>
</tr>
</tbody>
</table>

### POSITIVE TB SCREEN

(Recent or past)

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

<table>
<thead>
<tr>
<th>C. POSITIVE skin test (reading &gt; 10 mm):</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD read date ____ / ____ / ____ Reading _____ mm</td>
</tr>
<tr>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>Positive IGRA Blood Test (QuantiFERON or T-SPOT testing):</td>
</tr>
<tr>
<td>Test date _____ / _____ / ____</td>
</tr>
<tr>
<td>Result ___________ □ Copy Attached</td>
</tr>
</tbody>
</table>

**AND**

<table>
<thead>
<tr>
<th>Chest X-ray Report (required):</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray results: □ normal □ abnormal</td>
</tr>
<tr>
<td><strong>AND</strong></td>
</tr>
<tr>
<td>Prophylactic medications for latent TB taken:</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Date started: _____ / _____ / ____ Date ended: _____ / _____ / ____</td>
</tr>
<tr>
<td>Length of treatment ______ months</td>
</tr>
</tbody>
</table>

### TB SCREENING QUESTIONS: REQUIRED

| Have you ever received BCG? | □ yes □ no | if yes: Year __________ Country __________________________ |
| Have you traveled and/or lived overseas in the past year? | □ yes □ no | if yes: Countries __________________________ Last return date __________ |
| Have you worked in a prison or homeless shelter in the past year? | □ yes □ no |
| Have you entered a TB isolation room in the past year? | □ yes □ no |
## TB Screening Questions: Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had exposure to a known case of TB in the past year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past six months have you experienced any of the following for greater than three weeks?</td>
<td></td>
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</tr>
<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>

**History of Active TB (Recent or past)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of diagnosis: / /       Date treatment completed: / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest X-ray Report (required): X-ray results: normal normal Date: / /</td>
<td></td>
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</tr>
</tbody>
</table>

I certify that I performed a physical exam on the above named student on ________________ (date). This student is in good health and is free of contagious disease. To the best of my knowledge, the student is free from any health impairment which is of potential risk to patients or which might interfere with the performance of assigned 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 ____________________________

Physician, Nurse Practitioner, or Physician’s Assistant

Provider’s name printed ____________________________ License number ____________________________

Physician, Nurse Practitioner, or Physician’s Assistant

Clinician/Practice stamp
PHYSICAL EXAM FORM

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

Date of exam must be within 12 months of program start date.

Name: ____________________________________________

Last     First     Middle Initial

UNI: ____________________

Date of Birth: _____/_____/______

CUMC School: ________________  □ Part-time  □ Full-time

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

Visual Acuity:
(with correction, if any)

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, or Physician’s Assistant

Telephone number _________________________________ License number________________

Clinician/Practice stamp