Dear New Student,

Welcome to Columbia University Irving Medical Center (CUIMC). 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. The information is required for participation in the non-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,
CUIMC Student Health Service

How to Submit Your Preregistration Requirements

Deadline Dates:
• Summer 2019 Enrollment: April 26, 2019
• Fall 2019 Enrollment: June 28, 2019
• Spring 2020 Enrollment: December 16, 2019

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: 212-342-3955
• Postal Mail is strongly discouraged. Be sure to keep original copies if mailed:
  U.S. Postal Address: CUIMC Student Health Service, 100 Haven Avenue, 2nd Floor, New York, NY 10032
  FedEx Address: CUIMC Student Health Service, 100 Haven Avenue, 2nd Floor, NY 10032 (accepted 8 a.m.-5 p.m.)
CUIMC PREREGISTRATION HEALTH REQUIREMENTS

All information sent to CUIMC Student Health Service (SHS) is confidential and part of your medical record. It will be stored in a secure, confidential electronic medical record system accessible only to SHS staff.

| □ HEALTH HISTORY REQUIRED | Health History:  
• Must be entered online after you receive your Columbia UNI.  
• Enter at cuhs.studenthealthportal.com. |
| □ MENINGITIS VACCINE RESPONSE FORM REQUIRED | Meningococcal Meningitis Response Form:  
• Must be entered online after you receive your Columbia UNI.  
• Enter at cuhs.studenthealthportal.com.  
• Receipt of the vaccine is optional.  
• Information on the vaccine is available at: cdc.gov/meningococcal/vaccine-info.html. |
| □ MEASLES (RUBEOLA), MUMPS, RUBELLA (MMR) REQUIRED | MMR vaccine or Immunity  
• Dates of two doses of vaccine after one year of age.  
• **NOTE:** Vaccine doses must be at least 28 days apart.  
  OR  
• Positive MMR IgG Antibody titer (submit titer lab report). |
| □ TUBERCULOSIS SCREENING REQUIRED | PPD Skin Testing:  
• One PPD (tuberculosis screening) skin test administered within twelve months of program start date.  
  OR  
• Documentation of a negative QuantiFERON Gold or T-SPOT test completed within 12 months |

**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 | POSITIVE Skin Test (Reading > 10 mm) History:  
• Submit date and mm reading of your positive PPD and report of a chest x-ray completed after positive test.  
**Note:** TB skin tests can be placed by your Health Care Provider. |
**STEP 1: COMPLETE YOUR HEALTH HISTORY AND MENINGOCOCCAL RESPONSE ONLINE**
Once your Columbia UNI has been assigned, you can access our secure 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.

**STEP 2: GATHER PAST IMMUNIZATIONS RECORDS**
If you already have your official immunization records available to you, you will not need a health care provider to complete the immunization form found at the end of these instructions. However, you will most likely need to schedule a TB skin test appointment. If you received health services outside the U.S., documents must be in English. You must submit copies of all lab reports. **Keep a copy of all documentation for your personal records.**

**STEP 3: IF NECESSARY, MAKE AN APPOINTMENT TO GET MISSING IMMUNIZATIONS, TITERS, AND TUBERCULOSIS SCREENING**
You may need to visit a medical provider to complete your preregistration requirements. Bring copies of all immunization records. Your providers will complete and sign the Immunization form.

**STEP 4: SUBMIT YOUR COMPLETED IMMUNIZATION FORM AND REQUIRED ATTACHMENTS PRIOR TO DEADLINE DATE**
Submit after your Columbia UNI has been assigned.

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

**STEP 5: CHECK YOUR CLEARANCE STATUS VIA THE WEB PORTAL OR YOUR SSOL ACCOUNT**
Log into [cuhs.studenthealthportal.com](http://cuhs.studenthealthportal.com), click on “My Profile” and select “Immunization History” to verify clearance (please allow three weeks for processing). 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. CUIMC 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 CUIMC-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/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.

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

*Thank you! We look forward to serving as your healthcare partner while you are at CUIMC!*
IMMUNIZATION FORM: NON-CLINICAL PROGRAMS

This form must be completed by an MD/DO, NP, or PA who is not a relative. Please ensure form is complete and has a health care provider signature. Attach 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: ________________________________________________________

Last       First     Middle Initial

Date of Birth: ___________   CUIMC School: ________________________

mm/dd/yyyy

Contact Telephone: (_______) - _________________________

□ Male  □ Female  □ Transgender

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

• 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: _____ /_____ /_____

TB SCREENING (REQUIRED)

• Please complete one TB section only.
• Testing is required regardless of prior BCG status

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 testing: PPD skin test administered in the twelve months preceding program start date.

PPD test placement _____ /____ /___ Reading ___ /____ /___ reading _____ mm

□ Result Interpretation Negative  □ Result Interpretation Positive

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 twelve months of program start date.

Test date _____ /_____ /____ (only a negative test meets requirement)

Result ___________ □ Copy Attached
<table>
<thead>
<tr>
<th>POSITIVE TB SCREEN</th>
<th>C. POSITIVE skin test (reading &gt; 10 mm):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• History of latent TB, positive skin test or positive blood test complete C</td>
<td></td>
</tr>
<tr>
<td>PPD read date _____ / _____ / ____ Reading _____ mm</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSITIVE TB SCREEN (CONTINUED)</th>
<th>Positive IGRA Blood Test (QuantiFERON or T-SPOT testing):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test date _____ / _____ / ____</td>
<td></td>
</tr>
<tr>
<td>Result ___________ □ Copy Attached</td>
<td></td>
</tr>
<tr>
<td>AND</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chest X-ray Report (required):</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray results: □ normal □ abnormal Date: _____ / _____ / ____ □ Copy Attached</td>
</tr>
<tr>
<td>AND</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prophylactic medications for latent TB taken:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Date started: _____ / _____ / ____ Date ended: _____ / _____ / ____</td>
</tr>
<tr>
<td>Length of treatment _____ months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TB SCREENING QUESTIONS: REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever received BCG? □ yes □ no if yes: Year ______________ Country __________________________</td>
</tr>
<tr>
<td>Country of birth __________________________</td>
</tr>
<tr>
<td>Have you traveled and/or lived overseas in the past year? □ yes □ no if yes: Countries __________________________ Last return date ____________</td>
</tr>
<tr>
<td>Have you worked in a prison or homeless shelter in the past year? □ yes □ no</td>
</tr>
<tr>
<td>Have you entered a TB isolation room in the past year? □ yes □ no</td>
</tr>
<tr>
<td>Have you had exposure to a known case of TB in the past year? □ yes □ no</td>
</tr>
<tr>
<td>In the past six months have you experienced any of the following for greater than three weeks?</td>
</tr>
<tr>
<td>Excessive sweating at night □ yes □ no</td>
</tr>
<tr>
<td>Excessive weight loss □ yes □ no</td>
</tr>
<tr>
<td>Persistent coughing □ yes □ no</td>
</tr>
<tr>
<td>Excessive Fatigue □ yes □ no</td>
</tr>
<tr>
<td>Coughing up blood □ yes □ no</td>
</tr>
<tr>
<td>Hoarseness □ yes □ no</td>
</tr>
<tr>
<td>Persistent fever □ yes □ no</td>
</tr>
</tbody>
</table>
## HISTORY OF ACTIVE TB
(Recent or past)
- History of latent TB, positive skin test or positive blood test complete D

### D. History of Active TB:
- Date of diagnosis: _____ / _____ / _____
- Date treatment completed: _____ / _____ / _____

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

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**I attest that all dates, results, and immunizations listed on this form are correct and accurate.**

Provider’s signature ___________________________ Date________________________

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

Provider’s name printed____________________________ License number_____________

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

Clinician/Practice stamp