Icahn School of Medicine at Mount Sinai

Student Health Center
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574
Telephone: (212) 241-6023
E-mail: studenthealth@mssm.edu

Student Health Form

Section A: To Be Completed By Student			
Name (First, Middle, Last)	**Date of Birth** (MM/DD/YY)	**Telephone**	**E-mail address**
Program	**Sex at Birth**	**Gender Identity**	**Preferred Gender Pronoun**

Section B: Must be completed by an MD/DO, NP or PA who is not a relative. Attach all required laboratory and x-ray reports.	
Allergies and reactions	
Past medical history	
Past surgical history	
Hospitalizations	
Mental health	
Medications and dosages	
Family history	

PHYSICAL EXAM

BP: _____ **HR:** _____ **WT:** _____ **HT:** _____

	Normal	**Significant findings**
General appearance	☐	
HEENT	☐	
Heart	☐	
Lungs	☐	
Abdomen	☐	
Back	☐	
Extremities	☐	
Skin	☐	
Neurologic	☐	
If applicable, date of last cervical PAP smear	☐	
If applicable, does the applicant have a habituation or addiction to depressants, stimulants, alcohol or other drugs, which would alter their behavior?	☐	

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Name (First, Middle, Last)	**Date of Birth (MM/DD/YY)**

IMMUNIZATIONS

Required Immunizations:

- **Hepatitis B** *(Vaccination Dates AND Positive Titer)*
- **Varicella** *(Vaccinations Dates OR Positive Titer)*
- **Measles (Rubeola), Mumps and Rubella (MMR)** *(Vaccinations Dates OR Positive Titer)*
- **Tdap** *(Vaccination Date only)*
- **Influenza** (*Vaccination Date only*) **– *Required for Spring matriculating students only***

Strongly Recommended Immunizations:

- **COVID-19 vaccine** (*Vaccination Date only)*

Recommended Immunizations:

- **Hepatitis A**
- **Human Papillomavirus (HPV)**
- **Meningococcal**
- **Polio**

Please attach Lab Reports for Titer Results. Lab reports MUST include full name, date of birth, lab result and reference ranges.

REQUIRED IMMUNIZATIONS

Hepatitis B 3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines ***OR*** 2 doses of Heplisav-B vaccine	**Date 1** (MM/DD/YYYY)	**Date 2** (MM/DD/YYYY)	**Date 3** (MM/DD/YYYY)	***AND*** *Positive Hepatitis B surface IgG antibody titer at least 30 days after last dose (quantitative result preferred)* **MUST ATTACH LAB REPORTS** **Hepatitis B Surface Antibody (IgG)** **Date:**_____ **Serology Result:** **Quantitative Test** _____ MIU/ml ***OR*** **Qualitative Test** ☐ Reactive ☐ Non-reactive If result is "Not Reactive" or below designated lab cutoff, initiate Hepatits B booster series

Hepatitis B Boosters MUST initiate Hepatitis B booster series if antibody titer result is "Not reactive" or below designated lab cutoff		**Date 1**	**Date 2**	**Date 3**
	Heplisav-B			
	Energix-B (or other 3 dose series)			

Varicella **Option 1: Two doses of Varicella vaccine after first birthday, at least one month apart**	**Date 1** (MM/DD/YYYY)	**Date 2** (MM/DD/YYYY)	***OR*** **Option 2:** Positive titers (IgG) showing immunity to varicella **MUST ATTACH LAB REPORTS**

	Date	**Serology Result**
Varicella IgG		☐ Reactive ☐ Non-reactive
If result is "Non-Reactive", Varicella Booster must be initiated		**Varicella Booster** Date: _____

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REQUIRED IMMUNIZATIONS (continued)

Measles (Rubeola), Mumps & Rubella (MMR)

OR Option 3:
Positive titers (IgG) showing immunity to measles, mumps and rubella
MUST ATTACH LAB REPORTS

Option 1: Two doses of MMR vaccine after first birthday, at least one month apart

OR Option 2: Two doses of measles vaccine, two doses of mumps vaccine, and one dose of rubella vaccine

	Date (MM/DD/YYYY)	**Date** (MM/DD/YYYY)
MMR	#1	#2
Measles	#1	#2
Mumps	#1	#2
Rubella	#1	

	Date	**Serology Result**
Measles IgG		☐ Reactive ☐ Non-reactive
Mumps IgG		☐ Reactive ☐ Non-reactive
Rubella IgG		☐ Reactive ☐ Non-reactive

If result is "Non-Reactive", MMR Booster must be initiated

MMR Booster
Date: _____

Tdap One dose of TDAP vaccine within the past 10 years	**Date** (MM/DD/YYYY)	
Influenza (*Required for Spring matriculants only)* One dose, in line with seasonal availability (given in/after August in the Northern Hemisphere)	**Date** (MM/DD/YYYY)	

STRONGLY RECOMMENDED IMMUNIZATIONS

Covid-19 Vaccine One dose of updated formulation	**Manufacturer** *(Pfizer, Moderna, Novavax preferred)*	**Date** (MM/DD/YYYY)

RECOMMENDED IMMUNIZATIONS

Hepatitis A	#1	#2		
Human Papillomavirus (HPV)	#1	#2	#3	
Meningococcal Select booster brand	☐ **Menactra Date:** _____ **or** ☐ **Menveo Date:** _____			
Polio	#1	#2	#3	#4

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TUBERCULOSIS SCREENING

Complete Option A if you do not have a history of Tuberculosis (eg: you have never tested positive for TB)
Complete Option B if you recently tested positive or have a history of positive Tuberculosis

Option A: No history of Tuberculosis

Please complete one of following **MUST be within 6 months of program start date**:

Test Type	**Date**	**Result / Interpretation**
IGRA (Quantiferon or T-spot) **MUST ATTACH LAB REPORTS**		☐ Positive ☐ Negative
PPD	**Plant _____ / Read_____**	☐ Positive ☐ Negative If Positive: _____ mm

Option B: Recent or History of Positive TB test

Positive Test *(Must attach lab report)*	**Chest X-Ray** *(Must attach report)*
Date:_____ Test Type (circle one): ☐ IGRA ☐ PPD _____ mm	Date:_____ Results: _____

Treatment History
Did you receive treatment for Latent or active TB? ☐ Yes ☐ No
Medication(s) Taken: _____
Dates Started and Completed: _____

Last TB symptom and risk questionnaire (*must be completed within 1 year of start date*):
Date:___/___/_____ Results: ☐ Negative ☐ Positive (if positive, please provide updated CXR and result)

PROVIDER ATTESTATION

In compliance with the New York State Health code, I have examined the above named student who is free from any health impairment that would pose a potential risk to patients or hospital personnel. The health status of the above named individual should not interfere with the performance of his/her duties. I attest to all of the information this form. ☐ **Yes, I attest to all of the information in this form.**	**Provider name, title and license number:** **Provider signature:** **Today's Date (MM/DD/YYYY):** **Office Stamp:**