MOUNT SINAI SCHOOL OF MEDICINE MEDICAL STATUS FORM
TO BE COMPLETED BY STUDENT:

Name of Student ____

Do you have any physical defects or any history of illness, which might interfere with your functioning on a clinical service?
YES __ NO__

If yes, please specify:
____

TO BE COMPLETED BY MEDICAL PROVIDER:
Tuberculin skin test

Yearly PPD testing is required for all previous non-responders. Prior history of BCG is not acceptable as proof of positive PPD. Sputum of AFB is indicated for all persons with symptoms of tuberculosis & positive PPD. Persons who have a history of tuberculosis of past PPD conversion must attest that they are free of chronic fever, chills, night sweats, persistent cough and/or hemoptysis. Isoniazid prophylaxis is required for all recent converters under the age of 35 & should be considered for others.
DATE _________________________ RESULT __________________ mm _____ positive _____ negative

If patient is PPD positive: Date of last chest x-ray (within the past year) ___________________________________
Result _________________ (copy of chest x-ray report must be submitted)

I attest that the patient is free of symptoms of tuberculosis. ____
Initials of medical provider

Measles Titer (copy of lab report required) ____________Immune __________Not Immune
If not immune, date vaccine given
Mumps Titer (copy of lab report required) ____________Immune __________Not Immune
If not immune, date vaccine given
Rubella Titer (copy of lab report required) ____________Immune __________Not Immune
If not immune, date vaccine given _________________________

Tetanus/diphtheria booster (required within past 10 years) DATE ____________________

Hepatitis B Vaccine Series #1 ______________ #2 ______________ #3 ______________
Hepatitis B Surface Ab (copy of lab report required) ____________________

History of Varicella (chicken-pox) _______Yes _______No
If No: Varicella Titer (copy of lab report required) __________Immune __________Not Immune
If negative titer, Varivax required (Dates) #1 ______________ #2 ______________

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 (including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances), which may alter the individual's behavior. In addition, I attest to all of the information above.

____ ____
Medical Provider's Signature Medical Provider's Signature

____
Date

____
Address / Telephone Number

Positive titer serology for Measles, Rubella, and Hepatitis B are required from foreign students .We will accept MMRs and a 3-dose series for Hepatitis B visiting students.