MEDICAL STUDENT HEALTH SERVICE
334 East 25th Street
New York, NY 10010
Telephone: 212-263-5489
Email: studenthealthservice@nyulangone.org

Dear Medical Student,

The Medical Student Health Service (SHS) welcomes you to the New York University Grossman School of Medicine. We are open five days a week and provide a variety of health services to all medical students. Our services are cost-free, you will be eligible for our services once your school year begins.

Our preadmission health requirements are listed below. All required health forms are included in this document and must be completed and received by Student Health no later than **Friday, May 17, 2024.** Please note these are preadmission requirements and **cannot be done at SHS.**

Please contact us as soon as possible if you are having a difficult time completing your requirements.

- **Submission Guidelines: Due Date 5/17/2024 (all except MyChart)**
  - **For each section** below, please submit ***one PDF file containing all documents*** (i.e. one PDF with combined pages for section 1, same for 2, etc.)
  - Note that **the forms provided in this packet must be completed and signed**, *supporting documentation will be accepted as supplemental, but will not be accepted in place of our forms.*
  - **Format & File Names:**
    - Save/ send as PDF attachments (no google drive links or image formats)
    - Save as: Last Name_ Section # (ex: Smith_Section1, Smith_Section2, etc.)
  - **Email submission is *strongly preferred*.**
    - Send to: studenthealthservice@nyulangone.org
    - alternatively fax submissions are accepted, Fax: 212-263-3280

Preadmission Requirements
(all items below are required)

Section 1. To be completed electronically *by the incoming student:*

A) **Medical history, identity questionnaire and MyChart registration**.
- *By approximately June 1, 2024* a MyChart activation link will be sent to the e-mail address you provided to Admissions. Click on the link and register your account by completing the demographics fields.
- Find and complete the mandatory Medical History form (part 1 & 2), & Identity questionnaire in your MyChart account virtual appointment.

B) **SHS patient Consent Form, Baseline TB Risk Assessment, & TB Symptom Screen –** completed and signed by the student, sent to SHS via email attachment in PDF format (other formats will not be accepted): StudentHealthService@nyulangone.org

C) **Fit Testing Questionnaire**

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Please share this document with your Healthcare Provider

Section 2. All forms to be completed by your physician:

- *Please retain the original hard copies, as you may be asked to provide them later.
- *Note that **the forms provided in this packet must be completed**, *supporting documentation will be accepted as supplemental, but will not be accepted in place of our forms.*
  - **E-mail** (**only PDF format will be accepted**): StudentHealthService@nyulangone.org.
  - **Fax:** 212-263-3280

A. Physical exam

a. *must be performed July 2023 or later*, to be completed and signed by your Health Care Provider.

B. Immunization record completed and signed by your Health Care Provider. The requirements include:

a. Two MMR vaccines
b. Adult Diphtheria/Tetanus/Pertussis (Tdap) vaccine after the age of 16 and within the past 10 (ten) years
c. Three Hepatitis B Vaccines
d. Meningococcal (MenACWY) vaccine after the age of 16
e. Two Varicella vaccines (if applicable)
f. A IGRA blood test for tuberculosis (Quantiferon Gold or T-Spot), *must be from April 2024 or later*

Section 3. Blood work: (Copies of original lab reports are required, must include name, DOB, lab info & reference ranges)

A. CBC and fasting lipid panel *(done January 2024 or later)*
B. Quantiferon Gold or T-Spot TB test *(done April 2024 or later)*
C. Blood titers indicating immunity to: *(done 2019 or later)*

i. Rubeola/Measles IgG
ii. Rubella IgG
iii. Mumps IgG
iv. Varicella IgG
v. Hepatitis B titers, Three (3) parts, must Include:
1. Hepatitis B surface antibody (this test result must include Quantitative value which is numerical; Qualitative values such as "Reactive" will not be accepted
2. Hepatitis B surface antigen
3. Hepatitis B core antibody total

We look forward to meeting you! Please email us with any questions.

Sincerely,

NYU Grossman SOM Medical Student Health Service Team

NYU Grossman School of Medicine

MEDICAL STUDENT HEALTH SERVICE
Patient Consent

PERMISSION FOR MEDICAL TREATMENT:
I hereby authorize the Student Health Service of New York University, Grossman School of Medicine to administer care and treatment. Such care may include evaluation and treatment of injuries and illnesses and the administration of medication orally or by injection. I also give permission to the Student Health Service to secure proper treatment for me, in case of medical or surgical emergency, if according to their best professional judgment; further delay might jeopardize my welfare.

Upon request, I may have HIV testing done at SHS. Testing is voluntary. The law protects the confidentiality of HIV test results and other related information. The law also prohibits discrimination based on an individual's HIV status. This consent for HIV testing will remain in effect while I am a student at NYU Grossman School of Medicine, unless I revoke it either orally or in writing. I am aware that:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment); by HIV-infected pregnant women to their infants during pregnancy or delivery; or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with AIDS can adopt safe practices to protect uninfected persons from acquiring HIV and infected people from acquiring additional strains of HIV.
- Anonymous testing is available at a public testing center.

PRIVACY AND CONFIDENTIALITY OF MEDICAL RECORDS:
The Student Health Service maintains the student's medical record on EPIC, the electronic medical record used at NYU Langone Health. In order to maintain your confidentiality, we have the ability to chart your encounter in a subsection of the Epic record that may only be accessed by Student Health Service providers. The only information that will be visible to other providers within NYU Langone Health is a record of your allergies, medications and laboratory results. Your health records are protected by the Family Education and Privacy Act (FERPA), as well.

PERMISSION FOR RELEASE OF INFORMATION:
I hereby authorize the Student Health Service to disclose my health information in the following limited circumstances:

- Providing health care to me. For example, the Student Health Service may share health information with individuals who provide or assist in the coordination or management of my health care.
- Providing immunization records and/or laboratory test results only, for clinical rotations in the various clinical sites.

I understand that I will need to provide additional written consent to have my medical records released under any other circumstances.

Sign below to indicate the following:
I have read and understand the Treatment Consent and Medical Records Policies above.

Student Name: (Please print clearly) _____ Date of Birth: _____

Social Security Number: _____

Signature: _____ Date: _____

Please email this page with your medical forms to: StudentHealthService@nyulangone.org
Address: Medical Student Health Service, NYU Grossman School of Medicine, 334 East 25th Street Suite 103, New York, NY 10010
Fax: 212-263-3280.

NYU Grossman School of Medicine

Medical Student Health Service
BASELINE TB RISK ASSESSMENT TOOL

This section is to be completed by student:

Student's name: _____ Class: _____

DOB: _____ Phone# _____

Address: _____

Student's Signature: _____Date: _____

Please answer Yes or No next to the following questions:

1. Have you lived in a country with high TB rates (any country other than USA, Canada, Australia, New Zealand, or those in Northern or Western Europe) for 1 month or more within the past year? ☐ YES ☐ NO

   If YES, please list the country and dates of stay:_____

2. Do you have a medical condition that causes your immune system to be suppressed or do you take medication that suppresses your immune system? ☐ YES ☐ NO
   (Examples: human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication)

3. Have you had close contact with someone who has had infectious TB disease since your last TB test? ☐ YES ☐ NO

NYU Grossman School of Medicine

Medical Student Health Service
TB SYMPTOM SCREENING TOOL

This section is to be completed by the student:

Student's name: _____ Class: _____

DOB: _____ Phone# _____

Address: _____

Student's Signature: _____Date: _____

Please place a check next to any of the following symptoms if you have experienced them during the past year. *If you do not have any symptoms, please check off "No symptoms/none of the above"*

- ☐ Persistent cough > 3 weeks
- ☐ Blood in sputum
- ☐ Chest pain with coughing
- ☐ Unintentional weight loss
- ☐ Night sweats or chills
- ☐ Persistent fever
- ☐ Unexplained fatigue
- ☐ No symptoms/none of the above

If you experienced any of the above symptoms, please provide further information about onset and duration of symptoms, and other explanatory details.

_____
_____
_____

DO NOT COMPLETE THE SECTION BELOW – FOR NYU STUDENT HEALTH SERVICE STAFF ONLY:

Date & result of last TB test: _____

Date & result of last Chest x-ray (if applicable): _____

Physical examination if indicated:

General: _____
HEENT: _____
Neck: _____
Lungs: _____
Heart/ Circulatory: _____
Abdomen: _____
Lymphatic: _____
Skin: _____
Other: _____

Summary and remarks: _____
MD/NP recommendations: _____
Signature of MD/NP: _____ Date: _____
Printed name of MD/NP: _____

Please submit this form as part of your pre-admission health requirements by emailing StudentHealthService@nyulangone.org

OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C to Sec. 1910.134:

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____ Date of Birth: _____

Name _____ Kerberos ID#: _____

Job Title Medical Student

Phone Number: _____ Height: ____ (ft) ____ (in) Weight ____ (lbs)

Has your employer told you how to contact the health care professional who will review this? Yes ◯ NO ◯

Check the type of respirator you will use (you can check more than one category):

a [X] N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b [ ] Other type

[X] Powered-air purifier

[ ] Half-face

[ ] Supplied-air

[ ] Full-facepiece type (includes gas mask)

[ ] Self-contained breathing apparatus

Have you worn a respirator in the past?: Yes ◯ NO ◯

If ``yes,'' what type(s): _____

Physical exertion while wearing a respirator [ ] Mild [ ] Moderate [ ] Strenuous

Maximum time you wear a respirator in a single day?: ____ hours

Do you exercise? Yes ◯ NO ◯

If ``yes,' describe how often and what exercise activities are: _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select ``yes'' or ``no'').

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ◯ NO ◯

If Yes, how many packs per day? [ ] 1/2 or less [ ] 1 [ ] 2 [ ] 2 or more

How many years have you smoked? [ ] 1-9 [ ] 10-19 [ ] 20-29 [ ] 30 or more

2. Have you ever had any of the following conditions?

Seizures (fits) Yes ◯ NO ◯

Diabetes (sugar disease) Yes ◯ NO ◯

Allergic reactions that interfere with your breathing Yes ◯ NO ◯

Claustrophobia (fear of closed-in places) Yes ◯ NO ◯

Trouble smelling odors Yes ◯ NO ◯

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis Yes ◯ NO ◯

Asthma Yes ◯ NO ◯

Chronic bronchitis: Yes ◯ NO ◯

Emphysema: Yes ◯ NO ◯

Pneumonia Yes ◯ NO ◯

Tuberculosis Yes ◯ NO ◯

Silicosis Yes ◯ NO ◯

Pneumothorax (collapsed lung) Yes ◯ NO ◯

Lung cancer Yes ◯ NO ◯

Broken ribs: Yes ◯ NO ◯

Any chest injuries or surgeries: Yes ◯ NO ◯

Any other lung problem that you've been told about: Yes ◯ NO ◯

Name _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ◯ NO ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ◯ NO ◯
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ◯ NO ◯
Have to stop for breath when walking at your own pace on level ground:	Yes ◯ NO ◯
Shortness of breath when washing or dressing yourself:	Yes ◯ NO ◯
Shortness of breath that interferes with your job:	Yes ◯ NO ◯
Coughing that produces phlegm (thick sputum):	Yes ◯ NO ◯
Coughing that wakes you early in the morning:	Yes ◯ NO ◯
Coughing that occurs mostly when you are lying down:	Yes ◯ NO ◯
Coughing up blood in the last month:	Yes ◯ NO ◯
Wheezing:	Yes ◯ NO ◯
Wheezing that interferes with your job:	Yes ◯ NO ◯
Chest pain when you breathe deeply:	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung	Yes ◯ NO ◯

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ◯ NO ◯
Stroke:	Yes ◯ NO ◯
Angina:	Yes ◯ NO ◯
Heart Failure:	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking):	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly):	Yes ◯ NO ◯
High blood pressure:	Yes ◯ NO ◯
Any other heart problem that you've been told about:	Yes ◯ NO ◯

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest :	Yes ◯ NO ◯
Pain or tightness in your chest during physical activity	Yes ◯ NO ◯
Pain or tightness in your chest that interferes with your job	Yes ◯ NO ◯
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ◯ NO ◯
Heartburn or symptoms that is not related to eating	Yes ◯ NO ◯
Any other symptoms that you think may be related to heart or circulation problems:	Yes ◯ NO ◯

7. Do you currently take medication for any of the following problems?

Breathing or lung problems:	Yes ◯ NO ◯
Heart trouble:	Yes ◯ NO ◯
Blood Pressure:	Yes ◯ NO ◯
Seizures(fits)::	Yes ◯ NO ◯

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)

Eye irritation:	Yes ◯ NO ◯
Skin allergies or rashes:	Yes ◯ NO ◯
Anxiety:	Yes ◯ NO ◯
General weakness or fatigue:	Yes ◯ NO ◯
Any other problem that interferes with your use of a respirator:	Yes ◯ NO ◯

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes ◯ NO ◯

Name _____

10. Have you ever lost vision in either eye (temporarily or permanently): Yes ◯ NO ◯

11. Do you currently have any of the following vision problems?

- Wear glasses: Yes ◯ NO ◯
- Wear contact lenses: Yes ◯ NO ◯
- Color blind: Yes ◯ NO ◯
- Any other eye or vision problem: Yes ◯ NO ◯

12. Have you ever had an injury to your ears, including a broken ear drum: Yes ◯ NO ◯

13. Do you currently have any of the following hearing problems?

- Difficulty hearing: Yes ◯ NO ◯
- Wear a hearing aid: Yes ◯ NO ◯
- Any other hearing or ear problem: Yes ◯ NO ◯

14. Have you ever had a back injury: Yes ◯ NO ◯

15. Do you currently have any of the following musculoskeletal problems?

- Weakness in any of your arms, hands, legs, or feet: Yes ◯ NO ◯
- Back pain: Yes ◯ NO ◯
- Difficulty fully moving your arms and legs: Yes ◯ NO ◯
- Pain or stiffness when you lean forward or backward at the waist: Yes ◯ NO ◯
- Difficulty fully moving your head up or down: Yes ◯ NO ◯
- Difficulty fully moving your head side to side: Yes ◯ NO ◯
- Difficulty bending at your knees: Yes ◯ NO ◯
- Difficulty squatting to the ground: Yes ◯ NO ◯
- Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes ◯ NO ◯
- Any other muscle or skeletal problem that interferes with using a respirator: Yes ◯ NO ◯

Any additional comments you would like to make:

_____

To the best of my knowledge, the information I have provided is true and accurate.

Employee/Student Signature: _____ **Date** _____

DC 05032024

Safety Policy 136, Appendix B

For Student Health Services Staff to Complete

Student Health Recommendation on Respirator Use

Name: _____ **Kerberos ID:** _____

Dept: Medicine **Job Title:** Medical Student

Bldg/Room #: _____ **Phone:** _____

I am a licensed healthcare professional, and have reviewed above individual's Medical Evaluation Questionnaire for respirator use. I have the following recommendations (as checked):

☐ Individual cannot be cleared for use of respirator.

☐ Individual is cleared for use of the following respirator(s) without restrictions:

- ☐ N95 Respirator
- ☐ Half-face, negative pressure, air purifying respirator
- ☐ Full-face, negative pressure, air purifying respirator
- ☐ Powered air purifying respirator (PAPR) with Level C protective clothing
- ☐ PAPR, but not Level C protective clothing
- ☐ Other (specify): _____

☐ Individual is cleared for respirator use with the following restrictions:

_____

_____

_____

Name of physician or licensed health care professional: _____

_____ _____

Signature Date

New York University Grossman School of Medicine Student Health Service

MEDICAL STUDENT HEALTH PHYSICAL EXAM FORM

(Must be completed by a health professional who is not a relative)

334 East 25th Street Suite 103, New York, NY 10010 Tel: 212-263-5489 Fax: 212-263-3280
E-mail (only PDF format will be accepted): StudentHealthService@nyulangone.org

Name: _____ Sex Assigned at Birth: Male ○ Female ○ Intersex ○
Last First MI

Pronouns: _____

Date of Birth: ____/____/____ SS# ____-____-____

Physical Exam must be done within 1 year of start date

Section 1: History

1. Any significant past medical History? Yes ○ No ○

If yes, please explain _____

2. Alcohol use: Yes ○ No ○ Specify drinks/ wk: _____
3. Tobacco use: Yes ○ No ○ Specify packs/wk: _____
4. Any allergies to medications? Yes ○ No ○ Specify: _____
5. Any latex or non-medication allergies? Yes ○ No ○ Specify: _____

6. Current Medications & doses including contraceptives, nonprescription medications, vitamins and supplements:

Section 2: Physical Exam

Height: _____ Weight: _____ BP: _____ Pulse: _____ Temp: _____ Date of Exam: _____

	Normal	Abnormal	Not Done	If abnormal, please explain
General Appearance	○	○	○	_____
Head	○	○	○	_____
Eyes	○	○	○	_____
Ears, Nose, Throat	○	○	○	_____
Neck	○	○	○	_____
Skin	○	○	○	_____
Lymph Nodes	○	○	○	_____
Breasts	○	○	○	_____
Heart	○	○	○	_____
Lungs	○	○	○	_____
Abdomen	○	○	○	_____
Genitalia	○	○	○	_____
Rectum	○	○	○	_____
Spine	○	○	○	_____
Extremities	○	○	○	_____
Neuro	○	○	○	_____

Does this student require ongoing medical care? Yes ○ No ○ Specify: _____

_____

Additional Comments: _____

_____

Signature of Health Care Provider: _____

Print Name, State & License #: _____

Office Address: _____ Office Telephone: _____

*Return all forms to Student Health Service at the above address, email or fax (email preferred)

New York University Grossman School of Medicine Student Health Service

MEDICAL STUDENT HEALTH IMMUNIZATION FORM

(Must be completed by a health professional who is not a relative)

334 East 25th Street Suite 103, New York, NY 10010 Tel: 212-263-5489 Fax: 212-263-3280
E-mail (only PDF format will be accepted): StudentHealthService@nyulangone.org

NAME: _____ **DATE OF BIRTH**: _____

***The following vaccines (numbers 1 through 7) are required for all students. Document dates as: MM/DD/YY.**

1. **(Measles/Mumps/Rubella): MMR #1** Date: _____ **MMR #2** Date: _____ Booster if needed: _____

2. **Tetanus Toxoid Diphtheria and Pertussis**
   Dates of primary series: _____
   Date of adult TDaP ***(must be after age 16 and within the last 10 years)***: _____
   Date of last Booster, **if different from above**: _____ (*circle one*): TDaP or Td

3. **Meningococcal (MenACWY)** ***(2nd dose must be given at AGE 16 or LATER)*** Dates: #1 _____ #2 _____
   Brand name: _____

4. **Hepatitis B Vaccine** Dates: #1_____ #2_____ #3_____ (Booster) Date: _____

5. **Polio (primary series)** Dates: _____ _____ _____ _____ _____ (Booster) Date: _____

6. **Varicella Vaccine** Dates: #1 _____ #2 _____ (Booster) Date: _____

7. **Tuberculin Test: Must be IGRA blood test (Quantiferon TB Gold Plus or T-SPOT TB test). MUST BE FROM APRIL 2024 or LATER.**

   IGRA Blood Test: Date: _____ Results*: _____ (report must be attached)

   ***If positive IGRA Blood Test**, please provide result and date of last chest x-ray (within the last year), **and** details & dates of treatment received:

   _____
   (Attach a copy of the chest x-ray report)

   ******If history of BCG Vaccine, please provide the date:*** _____

The following vaccinations are recommended but not required:

COVID-19 Vaccine **Brand:** _____ Dates: #1_____ #2_____ Booster(s) _____

Hepatitis A Vaccine Dates: #1_____ #2_____

HPV vaccine Dates: _____ _____ _____ (*circle one*) Gardasil 4 or Gardasil 9

Typhoid vaccine Date: _____ (*circle one*) oral or injection

Yellow Fever Vaccine Date: _____

Signature of Health Care Provider: _____

Print Name, State & License # _____

Office address _____ **Telephone:** _____

***Please attach titer reports for Rubeola, Mumps, Rubella, Varicella, & Hepatitis B, a Quantiferon or T-Spot TB test, and a CBC & fasting lipid panel, see instruction page for specific testing requirements.**

Return all forms to Student Health Service at the above address, email or fax (email preferred) DC 05032024

Reset