MEDICAL STUDENT HEALTH SERVICE
334 East 25th Street
New York, NY 10010
Telephone: 212-263-5489
Email: SHSNewStudentInfo@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 pre-admission health requirements are listed below. All required blood work, immunization and physical exam health forms and records outlined in this packet must be completed and received by Student Health no later than **Friday, May 16, 2025**, items completed online through MyChart are due June 6, 2025, details are below. Please note these are preadmission requirements and **cannot be done at SHS.**

There may be follow-up action required to meet criteria for clearance necessary for health care workers at our institution.

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

- **Submission Guidelines: Due Date 5/16/2025**
  - **For each section, 2, 3 and 4,** please submit ***one PDF file containing all documents*** (i.e. one PDF with combined documents for section 2, same for 3, etc.)
  - Note that **the forms provided in this packet must be completed and signed**.
  - **Format & File Names:**
    - Save/ send as PDF file 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: SHSNewStudentInfo@nyulangone.org
    - alternatively fax submissions are accepted, Fax: 212-263-3280

Preadmission Requirements

Section 1. To be completed *by the incoming student*. Note, you must be in the USA to access, due by June 6th, 2025

A) **MyChart registration and Questionnaires**

- *By approximately May 23, 2025* 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.

- You will be scheduled for a "Virtual Intake Visit," please note *you do not present to the visit*. **However, you must complete the assigned, mandatory forms assigned to prepare for your visit by**:
  - **TB questionnaire**
  - **OSHA Medical Clearance**
  - **Medical History and Supplement**
  - **Preferred Pronouns Questionnaire**
  - **SOGI**
  - **Consent**

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Please share this document with your Healthcare Provider

Section 2. Due May 15, 2025, 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**.
  - Send Physical Exam form and SHS Immunization and Health Form in one PDF file, as: Last Name_ Section #2. **E-mail** (**only PDF format will be accepted**): **SHSNewStudentInfo@nyulangone.org**

A. SHS Physical Exam Form

a. *must be dated July 2024 or later*, to be completed and signed by your Health Care Provider (may not be a relative).

B. SHS Immunization and Health Form completed and signed by your Health Care Provider, **additional details available on the form, please review with your provider.**

The completed form should include:

- MMR vaccines
- Hepatitis B Vaccines
- Adult Diphtheria/Tetanus/Pertussis (Tdap) vaccine after the age of 16 and within the past 10 (ten) years
- Meningococcal (MenACWY) vaccine after the age of 16
- Two Varicella vaccines (if received)
- Polio Vaccine Series
- **Required Serology and Bloodwork**
  - CBC and fasting lipid panel *(performed July 2024 or after)*
  - QuantiFERON Gold or T-Spot TB test *(performed April 2025 or after)*
  - Blood titers indicating immunity to: *(performed 2020 or after)*
    - Rubeola/Measles IgG
    - Rubella IgG
    - Mumps IgG
    - Varicella IgG
    - Hepatitis B titers, *Three (3) parts, must Include*:
      - Hepatitis B surface antibody *(this test result must include Quantitative value which is numerical; Qualitative values such as "Reactive" will not be accepted)*
      - Hepatitis B surface antigen
      - Hepatitis B core antibody total

Section 3. Due May 15, 2025 Supporting Documents, Immunizations

- As Indicated on the SHS Immunization and Health form, Supporting Documents must be submitted, please send immunization documents in one PDF file, as: Last Name_ Section #3

Section 4. Due May 15, 2025 Laboratory reports ***(Official Reports required, must include: Patient demographics on each page, collection dates, reference ranges for all testing, and laboratory information)***

- As Indicated on the SHS Immunization and Health form, official laboratory reports for all bloodwork must be submitted, please send laboratory reports in one PDF file, as: Last Name_ Section #4

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

Sincerely,
NYU Grossman SOM Medical Student Health Service Team

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): shsnewstudentinfo@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)

NYU Grossman Student Health Service Immunization & Health Form

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Cell Phone:		**City:**			
Primary Email:		**State & ZIP Code:**			

Attached immunization records and serology laboratory reports required. All Supporting Documentation must include demographics on each page and reference ranges must be included for all bloodwork. Titers must be dated 2020 or after. Follow-up may be required following negative serologic reports.

MMR (Measles, Mumps, Rubella) *– 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella;* ***and*** *serologic proof of immunity for Measles, Mumps and Rubella.* ***Titers dated 2020 or after. Follow-up may be required following negative serology. Attached records and serology laboratory reports required.***

Copy provided

Option 1	Vaccine	Date		
MMR *-2 doses of MMR vaccine*	MMR Dose #1			☐
	MMR Dose #2			
	MMR Dose # 3 (only if applicable)			
	Vaccine or Test	**Date**		
Measles *-2 doses of vaccine positive serology*	Measles Vaccine Dose #1		**Serology Results**	☐
	Measles Vaccine Dose #2		Qualitative Titer Results: ❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Mumps *-2 doses of vaccine positive serology*	Mumps Vaccine Dose #1		**Serology Results**	☐
	Mumps Vaccine Dose #2		Qualitative Titer Results: ❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Rubella *-1 dose of vaccine positive serology*		**Date**	**Serology Results**	
	Rubella Vaccine		Qualitative Titer Results: ❑ Positive ❑ Negative	☐
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Tetanus-diphtheria-pertussis *– One (1) dose of adult Tdap,* ***must be after age 16 and within last 10 years****.*				
	Tdap Vaccine (Adacel, Boostrix, etc)			☐
	Td Vaccine *(if received after last Tdap, does not replace Tdap within the last 10 years)*			
Varicella (Chicken Pox) - ***serology required****, and documentation of 2 doses of vaccine, if received*				
	Varicella Vaccine #1			☐
	Varicella Vaccine #2		**Serology Results**	
	Varicella Vaccine #3 (only if applicable)		Qualitative Titer Results: ❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Polio Vaccine, Primary Series				
Dates of all doses, please indicate type:*			*Please note, if you have not received or do not have documentation of your primary series, you do not need to repeat it, but please indicate.	☐
Meningococcal MenACWY* – *Most recent dose must be from after age 16*	Type of Vaccine (Brand):		*If a refusal form has been completed, please indicate date of refusal and attach form.	☐

NYU Grossman Student Health Service Immunization & Health Form

Name: _____ **Date of Birth:** _____

(Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination - *3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥10mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (<10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.*				Copy Provided
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, PreHevbrio, Recombivax HB, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**		☐
	Hepatitis B Vaccine Dose #1				
	Hepatitis B Vaccine Dose #2				
	Hepatitis B Vaccine Dose #3				
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml		
Additional doses of Hepatitis B Vaccine *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**		☐
	Hepatitis B Vaccine Dose #4				
	Hepatitis B Vaccine Dose #5				
	Hepatitis B Vaccine Dose #6				
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml		
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.				

Additional Documentation			
Please provide documentation of any additional Vaccines you have a record of below, these are not required:			
Vaccination, Test or Examination	**Date(s)**	**Result/Interpretation/ Additional Dates**	
COVID-19 Vaccines			☐
Pfizer-BioNTech COVID-19 vaccine			☐
or Moderna COVID-19 vaccine			☐
or Novavax COVID-19 vaccine (aged >12 yrs only)			☐
Hepatitis A Vaccine			
Yellow Fever Vaccine			☐
HPV Vaccine			☐
Typhoid Vaccine			

NYU Grossman Student Health Service Immunization & Health Form

Name: _____ **Date of Birth:** _____

(Last, First, Middle Initial) (mm/dd/yyyy)

TUBERCULOSIS (TB) SCREENING – *All U.S. healthcare personnel are screened pre-placement for TB. Two kinds of tests are used to determine if a person has been infected with TB bacteria: NYUGSOM requires a TB blood test (IGRA). Results of one IGRA blood test is required* ***regardless*** *of prior BCG status. If you have a history of a positive TST (PPD) >10mm or a positive IGRA blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.*

IGRA results must be from testing performed April 2025 or after.

All reports must be provided per instructions.

Tuberculosis Screening History

Please complete only Section A or B depending on your TB History

Section A		**Date**	**Result**	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay) **Report must be provided**		❑ Positive ❑ Negative ❑Indeterminate	
Section B		**Date Placed**	**Date Read**	**Result**
History of Positive Skin Test or Positive Blood Test	Positive TST			_____ mm
	OR		**Date**	**Result**
	Positive QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray, **within 1 year of matriculation***			*Provide documentation and result:
	Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
	If treated, please indicate details about the treatment: (medication name & dose, length of treatment with dates)			
	Date of Last Annual TB Symptom Questionnaire			

Additional Required Bloodwork (Official reports must be submitted, demographics, reference ranges and laboratory information must be included, please see letter for submission instructions)

		Reports Provided
	CBC (performed July 2024 or after)	☐
	Lipid Panel (performed July 2024 or after)	☐
	Hepatitis B Surface Antigen (performed 2020 or after)	☐
	Hepatitis B Core Antibody (performed 2020 or after)	☐

NYU Grossman Student Health Service Immunization & Health Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL (May Not Be A Family Relation):

Healthcare Professional Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) _____-_____ **Ext:** _____	
Fax:	(____) _____-_____	
Email Contact:		

*Sources:

1. Haber P, Schille S. Chapter 10: Hepatitis B Pink Book. CDC https://www.cdc.gov/pinkbook/hcp/table-of-contents/chapter-10-hepatitis-b.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/hepb.html
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid+mm6819a3_w