Dear Medical Student,

The Medical Student Health Service welcomes you to the New York University Grossman School of Medicine. We are open throughout the year to provide a variety of services to all medical students. The Student Activity Fee included in your tuition covers the cost of care received at the Student Health Service, and 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 file and must be completed and received by our office no later than Friday, May 19, 2023. 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.

Please share this page with your physician

Preadmission Requirements (all items below are required):

1. **To be completed electronically by the incoming student:**
   - Medical history, identity questionnaire and MyChart registration.
     - By approximately May 19, 2023, 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.
   - **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

2. **All items to be completed by your physician and returned to the NYU Grossman School of Medicine Student Health Service by postal mail, email, or fax**: *Email is preferred.
   *Please retain the original hard copies, as you may be asked to provide them later.

   - **Mailing address:** NYU School of Medicine Student Health Service, 334 East 25th Street, Apt. 103, New York, NY, 10010 Fax: 212-263-3280

   - **E-mail (only PDF format will be accepted):** StudentHealthService@nyulangone.org

   **A. Physical exam, done January 2023 or later, to be done by your Health Care Provider.**

      **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. Menactra or Menvoe (meningococcal) vaccine after the age of 16
      e. Two Varicella vaccines (if applicable)
      f. IGRA blood test for tuberculosis (Quantiferon Gold or T-Spot), must be from April 2023 or later
      g. COVID-19 Vaccine Documentation – please include Mandatory Booster vaccine date

   **B. 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 2023 or later)*
      b. Quantiferon Gold or T-Spot TB test *(done April 2023 or later)*
      c. Blood titers indicating immunity to: *(done 2017 or later)*
         i. Rubeola/Measles IgG
         ii. Rubella IgG
         iii. Mumps IgG
         iv. Varicella IgG
         v. Hepatitis B titers - three parts [Must Include: 1) HB surface antibody (this test result must include quantitative value), 2) HB surface antigen & 3) HB core antibody total]

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

Sincerely,
NYU Grossman SOM Medical Student Health Service Team
Name: ______________________________________   Sex Assigned at Birth:  Male ☐ Female ☐ Intersex ☐ Date of Birth: ___/___/______   SS# _______-____-____

Last                                  First          MI

Pronouns: ____________________________

Physical Exam must be from January 2023 or later

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: ____________

General Appearance        Normal [ ]    Abnormal [ ]    Not Done [ ]    If abnormal, please explain ______________________________________________________________________________________

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)
NAME: ___________________________ DATE OF BIRTH: ________________

*The following vaccines (numbers 1 through 8) are required for all students. Document dates as: MM/DD/YY.

1. (Measles/Mumps/Rubella): MMR #1 Date: __________ MMR #2 Date: __________
   (Booster) Date: ______________

2. Tetanus Toxoid or Diphtheria-Tetanus Toxoid
   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 Vaccine (RECEIVED AGE 16 or LATER) Date: ______________ (circle one): Menactra or Menveo

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. COVID-19 Vaccine (attach documentation) Brand: __________ Dates: #1________ #2________ Booster

8. Tuberculin Test: Must be IGRA blood test (Quantiferon TB Gold Plus or T-SPOT TB test). MUST BE FROM APRIL 2023 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:

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: ________________

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

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

- 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 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
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.

2/1/2023