



MEDICAL STUDENT HEALTH SERVICE

334 East 25th Street
New York, NY 10010
Telephone: 212-263-5489

Dear Medical Student,

The Medical Student Health Service welcomes you to the New York University School of Medicine. We are open throughout the year to provide a variety of services to all medical students. 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 folder and must be completed and received in our office no later than **Friday, June 26, 2020**. Please note that a physical examination, certain vaccinations, and blood titers are preadmission requirements that usually 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 (you will receive this by June 1):

- **Medical history, identity questionnaire and MyChart registration.**
 - 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.

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*.

*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.

***Physical exam**, *within a year of July 1, 2020*, to be done by your Health Care Provider.

***Immunization record** completed and signed by your Health Care Provider.

The immunization 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 Menveo (meningococcal) vaccine after the age of 16
- e. A PPD Mantoux skin test or IGRA test for tuberculosis, done January 2020 or after
- C. **Blood work: (Copies of original lab reports are required, must include name, DOB, lab info & reference ranges)**
 - a. CBC, fasting lipid panel (**within a year of July 1, 2020**)
 - b. Blood titers indicating immunity to: (**done 2015 or after**)
 - i. Rubeola
 - ii. Varicella
 - iii. Rubella
 - iv. Mumps
 - v. Hepatitis B, three parts [Must Include: 1) HB surface antibody (this test result must include quantitative value), 2)HB surface antigen qualitative & 3)HB core antibody qualitative]

3. SHS patient consent form - signed by the student, sent to SHS with items in section 2.

We look forward to meeting you! Please call 212-263-5489 for 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 212-263-5489

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

Name: _____ Class _____ Gender: M ___ F ___ Date: _____
Last First MI

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

Physical Exam must be from July 2019 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 incl. contraceptives, nonprescription medications, vitamins and supplements:

Section 2: Physical Exam

Height: _____ Weight: _____ BP: _____ Pulse: _____ 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: _____

New York University Grossman School of Medicine Student Health Service

MEDICAL STUDENT IMMUNIZATION RECORD

334 East 25th Street Suite 103, New York, NY 10010 tel. (212)-263-5489 fax. (212)-263-3280

Email: StudentHealthService@nyulangone.org

NAME: _____ BIRTHDATE: _____

***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: _____

OR (a, b & c, below)

a. Rubeola Vaccine (Measles) #1 Date: _____ #2 Date: _____

b. Mumps Vaccine Date: _____

c. Rubella Vaccine (German Measles) 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 (Menactra/Menveo) Vaccine (RECEIVED AGE 16 or LATER)** Date: _____

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

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

6. **Varicella Vaccine** Dates: #1 _____ #2 _____

7. **Tuberculin Test (Mantoux)*: PPD or IGRA. MUST BE FROM JANUARY 2020 or LATER.**

Date PPD planted: _____ Date read: _____ Results: _____ mm Positive* [] Negative []

Quantiferon Gold Test: Date: _____ Results*: _____ (report must be attached)

*If positive PPD or QFT, 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 Date: _____ (*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 (3 parts), 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.

4/14/2020

05/05/2020



MEDICAL STUDENT HEALTH SERVICE

Patient Consent

PERMISSION FOR MEDICAL TREATMENT:

I hereby authorize the Student Health Service of New York University, 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 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 NYULMC. 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 the NYU Medical Center is a record of your allergies, medications and lab results. This information is HIPPA protected, 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 mail this page with your medical forms to:
Medical Student Health Service, NYU School of Medicine, 334 East 25th Street Suite 103, New York, NY 10010
Or fax to: 212-263-3280.