MEDICAL STUDENT HEALTH SERVICE
222 Station Plaza North Suite 104
Mineola, NY 11501
Telephone: 516-240-7200 option 3 Fax: 516-663-1877

Dear Medical Student,

The Medical Student Health Service welcomes you to the New York University Grossman Long Island School of Medicine. We are open throughout the year to provide a variety of services to all medical students. Your student activity fee covers the cost of care received in the Student Health Service office, 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, 2026.** Please note that the physical requirements **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): Please submit one PDF with all.

1. **All items to be completed by your physician and returned to the NYU Grossman Long Island School of Medicine Student Health Service by email.**
   *Please retain the original hard copies, as you may be asked to provide them later.
   - **E-mail** (**only PDF format will be accepted**): medli.studenthealthservice@nyulangone.org or Donna.Montesano@nyulangone.org

   A. **Physical exam**, *within the past 6 months*, to be done 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 Diptheria/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. Two Varicella vaccines (if applicable)
      f. A IGRA blood test for tuberculosis (Quantiferon Gold or T-Spot), within 3 months of matriculation or later

   C. **Blood work** within the past year: (**Copies of original lab reports are required, must include name, DOB, lab info & reference ranges)**
      a. CBC, fasting lipid panel (*done January 2026 or later)*
      b. Quantiferon Gold or T-Spot TB test, within 3 months of matriculation or later
      c. Blood titers indicating immunity to: *(done 2025 or later)*
         i. Rubeola / Measles IgG
         ii. Rubella IgG
         iii. Mumps IgG
         iv. Varicella IgG
         v. Hepatitis B titers **(titers must include HBsAg, HBsAB quantitative value which is numerical, Core antibody total)**

2. **To be completed electronically by the incoming student:**
   - **Medical history, identity questionnaire and MyChart registration.**
     - A MyChart activation link will be sent to the email 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. Instructions will be given when all documentation received.
   - **SHS patient Consent form, Baseline TB Risk Assessment and OSHA Respirator Questionaire -** completed and signed by the student, sent to SHS via email attachment in PDF format ONLY: medli.studenthealthservice@nyulangone.org or donna.Montesano@nyulangone.org

Please call Donna Montesano at 516-663-1513 or email donna.montesano@nyulangone.org for any questions.

Sincerely,
NYU Grossman Long Island Medical Student Health Services Team

NYU Grossman Long Island School of Medicine

NYU Grossman Long Island School of Medicine

New York University Grossman Long Island School of Medicine Student Health Service

MEDICAL STUDENT HEALTH PHYSICAL EXAM FORM

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

222 Station Plaza North, Suite 104, Mineola, NY 11501 tel. (516) 240-7200 fax. (516) 663-1877
E-mail (only PDF format will be accepted): medli.studenthealthservice@nyulangone.org

Name: _____ Sex Assigned at Birth: M____ F____ Intersex____
Last First MI
Pronouns: _____

Date of Birth: _____/_____/_____ SS# _____/_____/_____

Section 1: History

1. Any significant past medical or surgical 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: _____ 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: _____

New York University Grossman Long Island School of Medicine Student Health Service

MEDICAL STUDENT IMMUNIZATION RECORD

222 Station Plaza North Suite 104, Mineola, NY 11501 tel. (516) 240-7200 option 3 fax. (516) 663-1877
E-mail: medli.studenthealthservice@nyulangone.org

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 Toxid or Diptheria- 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. **Tuberculin Test**: **Must be IGRA blood test (Quantiferon TB Gold Plus or T-SPOT TB Test)**
   Must be done within 3 months of matriculation 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

Signature of Health Care Provider: _____

Print Name, State & License # _____

Office address _____ **Telephone**: _____

***Please attach titer reports obtained within the last year 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.**

12/9/2025

NYU Grossman Long Island 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 Long Island 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 Long Island 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 NYUGLISOM. 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 Langone Health is a record of your allergies, medications and lab 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: medli.studenthealthservice@nyulangone.org
Address: NYU Grossman Long Island School of Medicine Student Health Service
222 Station Plaza North, Suite 104 • Mineola, NY 11501
Fax: 516-663-1877

NYU Grossman Long Island School of Medicine
STUDENT HEALTH SERVICE
BASELINE TB RISK ASSESSMENT TOOL

This section is to be completed by student

Student's name: _____ Class: _____
DOB: _____
Address: _____
Phone# _____

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

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 **medli.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 _____ SSN: _____

Job Title Student Sex: Male ◯ Female ◯

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

Work Phone: _____

Can you read English? . . . . . Yes ◯ NO ◯

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 ____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b ____ Other type

☐ Half-face ☐ Powered-air purifier

☐ Full-facepiece type (includes gas mask) ☐ Supplied-air

☐ 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 _____

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

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 Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

_____

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 ◯ 2 ◯ 3 ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

_____ _____ _____

Reviewer's Name (Print) **Reviewer's Signature** **Date:**

Reset Form

To be Reviewed by NYUGLISOM Student Health Services