NYU Long Island School of Medicine

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 New York University 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, 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 **Monday, July 6, 2020.** Please note that a physical examination, certain vaccinations, and blood titers are preadmission requirements that **cannot be done at SHS. Unfortunately we cannot make exceptions**. It is recommended that you share this letter with your physician.

Preadmission Requirements (all items below are required):

1. **All items to be completed by your physician and returned to the NYU Long Island 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 Long Island School of Medicine Student Health Service, 222 Station Plaza North, Suite. 104, Mineola, NY, 11501
- E-mail (only PDF format will be accepted): medli.studenthealthservice@nyulangone.org
- Fax: 516-663-1877

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 immunization requirements include:

- **a.** Two MMR vaccines
- **b.** Pertussis (Tdap) vaccine after the age of 10 or later
- **c.** Tetanus within the past 10 years
- **d.** Three Hepatitis B Vaccines
- **e.** Polio
- **f.** Varicella
- **g.** Menactra or Menveo (meningococcal) vaccine after the age of 16 and within the past 5 (five) years
- **h.** A PPD Mantoux skin test or IGRA test for tuberculosis within 3 months of matriculation

C. **Blood work** within the past year: (**Copies of original lab reports are required)**

- **a.** CBC, fasting lipid panel
- **b.** Blood titers indicating immunity to:
  - **i.** Rubeola
  - **ii.** Varicella
  - **iii.** Rubella
  - **iv.** Mumps
  - **v.** Hepatitis B titers **(titers must include HBsAg, HBsAB quantitative value)**

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

We look forward to meeting you! Please call 516-240-7200 option 3 for any questions.

Sincerely,
NYU Long Island Medical Student Health Services Team

DC 05/29/2020

05/22/2020

NYU 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
www.medli.nyu.edu/students/health-services

Name: _____Class _____ Gender: M___ F___ Date: _____
Last First MI

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: _____ 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: _____

NYU 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
www.medli.nyu.edu/students/health-services

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): on or after the first birthday 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** Dates of primary series: _____

   Date of last Booster, ***(must be within the last 10 years)***
   if different from above: _____ (*circle one*): TDaP or Td

3. **Pertussis** Date of Tdap ***(must be administered at age 10 or older)*:** _____

4. **Meningococcal (Menactra/Menveo) Vaccine** ***(after age 16 and within the last 5 years)*** Date: _____

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

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

7. **Varicella Vaccine** Dates: #1_____ #2_____ Disease: _____

8. **Tuberculin Test** (Mantoux)*: PPD or IGRA. **Must be done within 3 months of matriculation.**

   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 Dates: #1_____ #2_____ #3_____ (*circle one)* Gardasil 4 or Gardasil 9

Meningitis B Vaccine (Bexsero/Trumenba) Dates: #1_____ #2_____

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, and a CBC & fasting lipid panel from the last 6 months, see instruction page for specific testing requirements.**

Return all forms to Student Health Service at the above address or fax.

NYU Long Island School of Medicine

MEDICAL STUDENT HEALTH SERVICE
Patient Consent

PERMISSION FOR MEDICAL TREATMENT:
I hereby authorize the Student Health Service of NYU 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 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 NYULISOM. 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 Winthrop Hospital 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: NYU Long Island School of Medicine Student Health Service
222 Station Plaza North, Suite 104 • Mineola, NY 11501
Or by Fax: (516) 663-1877