ID#________

CERTIFICATE OF IMMUNITY

Select One: ☐ **TNY/COM** ☐**TNY/MBM** **Class of ______**

TOURO COLLEGE OF OSTEOPATHIC MEDICINE – NEW YORK
2090 Adam Clayton Powell Blvd New York, NY 10027
Telephone: (212) 851-1199 Facsimile: (212) 851-1183

Name ______________________________ **Sex** ________ **Date of Birth** ______________

Social Security #______________________ **Email** ______________________________

Address ____

Telephone ______________________ **Cell Phone** ______________________________

Emergency Contact Name/Telephone ____

Please read and sign in the box below:

I authorize TOUROCOM-NY to release all immunization records to external rotation (clerkship) sites and/or to the New York Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency or legally mandated reporting requirements.

Student Signature: ______________________________ **Date:** ______________________

A licensed HEALTH CARE PROVIDER must complete the following information. This form must be submitted to Student Health Services two months prior to Registration and prior to beginning classes. Positive titers are required for training at clinical rotation sites. Titers provide protective evidence of immunity from disease. The only exception is for an immunization series that requires minimum waiting periods between doses.

Titer Laboratory Reports
Give Dates and Attach Copies of Reports

Positive Measles (Rubeola), Rubella (German Measles), MumpsTiter IgG Date:

______________ ______________ ______________

Positive Varicella (Chicken Pox) Titer IgG Date:

____

Positive Hepatitis B Surf AB Titer Date:

____

Tetanus Booster (1 within past 10 years) Date: ______________________________

Recommended, but not required:
Hepatitis C Antibody Date: ____________ Result: ______________________________

Oral Polio or IPV Series (record doses):

#1____________ #2____________ #3____________ #4____________

TUBERCULOSIS SCREENING

(A) **STUDENTS WHO ARE NEGATIVE PPD REACTORS:** Mantoux Testing must be done within 1 year of starting Touro College of Osteopathic Medicine - NY

ID#__________

Date Applied: ____________________ Date Read: ____________________ Induration: ______ mm

(B) STUDENTS WHO ARE POSITIVE PPD REACTORS (LATENT Tb) OR CONVERTERS WITH PREVIOUSLY OR NEWLY POSITIVE SKIN TESTS.

First positive skin test date: ____________________ Result (mm) if known: ____________________

BCG given in past: _____ Yes _____ No (If yes, provide approximate date of last BCG ____________________)

Date of Last CXR: ____________ Result: ____________________ (Attach Copy – Must be within 2 years.)

Dates of any treatment (INH prophylaxis for 6-9 months): ____________________

If no treatment and under 35 years old, why was treatment not given? ____________________

Health Care Provider: I attest that all dates, immunizations and Tuberculosis screening results are correct and accurate.

Name (Print): ____________________
Address: ____________________
City, State: ____________________
Telephone: ____________________
Facsimile: ____________________
E-Mail: ____________________
Signature: ____________________
Date: ____________________

STUDENT REACTORS (LATENT Tb) OR CONVERTERS COMPLETE THE FOLLOWING SYMPTOM CHECKLIST:

Have you recently:

Had an unexplained cough lasting more than 4 weeks?	_____ Yes	_____ No
Had sputum production?	_____ Yes	_____ No
Had an unexplained fever?	_____ Yes	_____ No
Had unexplained weight loss?	_____ Yes	_____ No
Had fever, night sweats or chills?	_____ Yes	_____ No

Student Signature: ______________________________ Date: ____________________

Send the completed forms (Certificate of Immunity/Tuberculosis Screening, Health History/Physical Examination, and Supporting Documentation) to:

Student Health Services
Touro College of Osteopathic Medicine – New York
2090 Adam Clayton Powell Blvd, 5th Fl.
New York, NY 10027
Telephone: (212) 851-1199
Facsimile: (212) 851-1183

HEALTH HISTORY FORM – TO BE COMPLETED BY STUDENT

***Select One*:** ☐ **TNY/COM** ☐**TNY/MBM** **Class of ______**

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2090 Adam Clayton Powell Blvd New York, NY 10027
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Name ______________________________ **Sex** ________ **Date** ______________

Address ____

Date of Birth ______________________________ **Social Security #** ______________

Telephone ______________________________ **Cell** ___________________________

Email ____

Emergency Contact Name/Telephone ____

Past Health History (circle)
Hypertension Cancer Hepatitis A-B-C Ulcers Asthma Bronchitis Arthritis Thyroid
Anemia TB Diabetes 1-2 Kidney Disease Eczema Rheumatic Fever Heart Murmurs
Severe Eyesight Disturbances Severe Allergies Hearing Problems Blood Clots Stroke Ulcers
Sexually Transmitted Diseases (STD's) Depression Anxiety Suicidal Attempts Heart Disease
Elevated Lipids Back Deformities Locomotion Challenges Deafness Blindness Herpes
Speech Challenges Abnormal Pap Prostate Abnormalities Testicular Disease Mononucleosis

Past Surgical History ____

Hospitalizations - Injuries (dates/cause/treatments) ___________________________________
____

Social History Smoker ____ Years Alcohol ____ Drugs ___ Exposure to Environmental Toxins ___

Current Medications ____

Allergies Drug Allergy (names) ____
Environmental/Latex ____

Family History

Mother	L	D	Health Status
Father	L	D	Health Status
Children	L	D	Health Status
Siblings	L	D	Health Status

Symptom Review (circle) Fever Weight Gain/Loss Chills Sweats Loss of Appetite Nervous Tired Hair Loss Skin Rashes Sores Headache Blurred Vision Double Vision Ear Ringing Vertigo Trouble Hearing Frequent Nose Bleeds Sinus Troubles Bleeding Gums Frequent Strep Throat Neck Pains Chest Pains Shortness of Breath/Trouble Breathing Rapid Heart Beats Varicose Veins Scoliosis Kyphosis Wheezing Night Sweats Breast Lumps Breast Discharge Heartburn Rectal Bleeding Trouble Voiding Burning on Urination Testicular Masses Old Spinal Injuries Depression Anxiety Seizures

PHYSICAL EXAMINATION FORM–TO BE COMPLETED BY HEALTH CARE PROVIDER

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Telephone: (212) 851-1199 Facsimile: (212) 851-1183

Name ____

Date of Birth ______________________________ **Sex** ____________________

Height _______ **Weight** ________ **B/P** _______ **T** _______ **P** _______ **R** ________

Vision Distance Uncorrected R 20/____ L 20/ ____ Corrected R/20/ ____ L20/____

Color Vision Normal _____ Deficient _____

	Circle Normal	or Abnormal	Description of Abnormalities
Skin	n	a	
Eyes	n	a	
Ears	n	a	
Nose/Sinus	n	a	
Throat/Neck	n	a	
Chest/Thorax	n	a	
Heart	n	a	
Lungs	n	a	
Abdomen	n	a	
Extremities	n	a	
Osteopathic Structural Exam	n	a	
Neuro	n	a	
Psych/Mental	n	a	
Genito-Urinary	n	a	

I have examined this potential Touro College of Osteopathic Medicine - NY student and found that He/She:

A. May participate fully in all activities involved without restriction.
B. May participate with the following restrictions or accommodations.
C. May not participate, due to issues of safety/other.

Health Care Provider:

Name (Print): ______________________________
Address: ______________________________
City, State: ______________________________
Telephone: ______________________________
Facsimile: ______________________________
E-Mail: ______________________________
Signature: ______________________________
Date: ______________________________

TOURO COLLEGE
OFFICE OF THE REGISTRAR

Meningitis Response Form

In accordance with New York State Public Health Law, Touro College requires that all students complete and return this form to the College Registrar's Office.

What is meningococcal disease?
Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord.)

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data is available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?
The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?
High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?
The symptoms may appear 2 to 10 days after exposure, but usually within five days.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?
Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?
Contact your family physician or your student health service. Additional information is also available on the web sites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention, www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.

Check one box and sign below.

I have:

☐ had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date received _____/_____/_____

{Note: If you received the meningochoccal vaccine available before February 2005, called Menomune™, please note this vaccine's protection lasts for approximately 3-5 years. Revaccination with the new conjugate vaccine, called Menactra™, should be considered within 3-5 years after receiving Menomune™.)}

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis from my private health practitioner or when offered through Touro College.

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

Student's Signature (Parent/Guardian if student is under 18) — _____/_____/_____ *Date*

Print Student's Name — _____/_____/_____ *Student's Date of Birth*

Student's E-mail Address — *Student's ID or Social Security #*

Student's Mailing Address — *Number and Street* — *Appartment* — *City*

State — *Zip* — ( ) *Student's Phone Number*