YESHIVA UNIVERSITY

STUDENT MEDICAL INFORMATION

ATTENTION YU STUDENT

The Mount Sinai Beth Israel Student Health Services Network provides medical services to students on the Wilf and Beren campuses of Yeshiva University. To document your health status—and to ensure that you are compliant with New York State public health law—you must provide a complete immunization record, medical history, and evidence of a recent physical examination. **These documents must be submitted to YU before you can receive your housing assignment and register for classes.** The Health Services Network will communicate to Yeshiva University administrative personnel our assessment of your ability to mentally and physically perform as a student, without restriction and without any immediate or direct threat of harm to yourself or to others. Medical information will be released to others only when and if prescribed by law or with your or your guardian's consent.

Take care to complete every section and answer all questions. Make certain to print your name, date of birth, and YU ID# at the top of each page. If you will be under age 18 when you begin classes at the University, have your parent or guardian read, sign, and date the Parental Permission section on this page. **Pages 2–5 should be completed with your physician and should include an update of your immunization records. Your doctor must validate the following forms with his/her signature and an office stamp.**

Once you have completed these forms, fax all five pages to the appropriate campus health center, listed at the bottom of this form.

STUDENT INFORMATION

Name _____ YU ID# _____ Date of Birth _____

Home Address _____ Place of Birth _____

_____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Gender _____ U.S. Citizen? ☐ yes ☐ no

My Insurance Company _____ Date this form was submitted _____

PARENTAL PERMISSION

The law requires that parental consent be obtained to provide medical treatment, prescribe or dispense medications, or perform procedures on minors (persons under age 18). A parent or legal guardian should sign this consent form so that such treatment may be administered promptly and unnecessary delay avoided. Note: Except in a dire emergency, no operative procedure will be performed without parental notification and additional consent.

I give permission for such diagnostic, therapeutic, or emergency operative procedure as may be necessary to evaluate and treat my son/daughter or person named above for whom I am legal guardian.

Parent/Guardian *(print)* _____ Relationship _____

Parent/Guardian *(sign)* _____ Date _____

Emergency Contact # _____

Ask your health care provider to validate the information with a signature and office stamp. Return the completed packet by fax (and without a cover page) to your campus health center listed below. For additional information, please contact:

Student Health Center
Wilf Campus (Men)
Furst Hall, Room 520
500 West 185th Street
New York, NY 10033
Phone 646.592.4290
Fax 646.685.0395

Student Health Center
Beren Campus (Women)
50 East 34th Street, Room 2B
New York, NY 10016
Phone 212.340.7792
Fax 212.340.7858

DOCTOR: PLEASE FAX THIS PAGE TO THE APPROPRIATE CAMPUS HEALTH CENTER:

Wilf Campus (Men) fax: 646.685.0395 Beren Campus (Women) fax: 212.340.7858

In order to maintain the health of all students: New York State public health law requires that students attending postsecondary institutions in the state submit proof of immunization against certain vaccine preventable diseases. YU students may demonstrate immunity by presenting proof of having received two vaccinations for Rubeola (Measles), two vaccinations for Mumps, and at least one vaccination for Rubella (German Measles) or if given in combination, two M-M-R (Measles, Mumps and Rubella) vaccines. Immunity may also be affirmed by providing the results of a laboratory test (immune titer) for each disease.

Student's Name _____ YU ID# _____ Date of Birth _____

MANDATORY IMMUNIZATIONS

Two Measles Mumps and Rubella (MMR) vaccinations
- Date 1: Immunization no more than 4 days prior to student's first birthday — Date _____
- Date 2: Immunization at least 28 days after 1st vaccination — Date _____
- If born **before** 1957, indicate birth date — Date of Birth _____

OR

Two Measles (Rubeola) vaccinations
- Date 1: Immunization no more than 4 days prior to student's first birthday — Date _____
- Date 2: Immunization at least 28 days after 1st vaccination — Date _____
- Date of positive immune titer — Date _____

Rubella (German Measles) vaccination
- Date 1: Immunization with rubella vaccine, no more than 4 days prior to student's first birthday, and after January 1, 1957 — Date _____
- Date of positive immune titer — Date _____

Two Mumps vaccinations
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date _____
- Date of positive immune titer — Date _____

Physician Initials *(office stamp required)* _____

Note: While meningitis vaccination is recommended by the NYS Departmenet of Health but is not mandatory, a completed Meningitis Vaccination Response form (see below) must be submitted by every student.

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours or the equivalent per semester, or at least four semester hours per quarter, must complete and return this form.

COMPLETE THE INFORMATION SECTION BELOW; CHECK ONE RESPONSE BOX, SIGN AND DATE

I have:

☐ had the Meningococcal Meningitis immunization (Menomune™ or Menactra™) within the past 10 years.

Date received _____

☐ read the information regarding Meningococcal Meningitis, available on the Web at http://www.cdc.gov/meningococcal/, **or** http://www.health.ny.gov/diseases/communicable/meningococcal/fact_sheet.htm, **or** http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.pdf

I will obtain immunization against Meningococcal Meningitis within 30 days from my private health care provider or through the Beth Israel Student Health Services Network at Yeshiva University.

☐ read the information regarding Meningococcal Meningitis, available on the Web at http://www.cdc.gov/meningococcal/, **or** http://www.health.ny.gov/diseases/communicable/meningococcal/fact_sheet.htm

I understand the risks of not receiving the vaccine. I have decided I will **not** obtain immunization against Meningococcal Meningitis.

Signature _____ Date _____
Student (if 18 years or older), otherwise parent

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STUDENT MEDICAL INFORMATION *Additional immunization history*

Student's Name _____ YU ID# _____ Date of Birth _____

OTHER VACCINES (RECOMMENDED BUT NOT MANDATORY FOR ADMISSION)

Tetanus, Diphtheria, Pertusis (primary series completed) Date _____
Last booster (within 10 years) Date _____

Hepatitis A Series First _____ Second _____

Hepatitis B Series First _____ Second _____ Third _____

Varicella (Chicken Pox) Vaccine Date _____
Positive immune Titer to Varicella Date _____
OR
Date Varicella was diagnosed Date _____

Polio (If primary series completed, list the last booster) Date _____

OTHER TESTS (NOT MANDATORY FOR ADMISSION)

Tuberculosis skin test Date _____ Result: ☐ neg ☐ pos

If positive, date of chest X-ray Date _____ Result: ☐ neg ☐ pos

If positive, was prophylaxis given? ☐ yes ☐ no Dates: from _____ to _____

Name of Physician _____ Date _____

Physician's Signature _____

Physician Initials *(office stamp required)* _____

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STUDENT MEDICAL INFORMATION *Medical status*

Student's Name _____ YU ID# _____ Date of Birth _____
Height _____ Weight _____ BP _____ Pulse _____ Hearing: normal ☐ yes ☐ no
Vision: Right 20/ _____ Left 20/ _____ ☐ With glasses or contacts Color vision: normal ☐ yes ☐ no

SYSTEMS REVIEW	Normal: yes	no	Describe Abnormality
01. Loss or impaired function of any organ	☐	☐	
02. Allergic to medications	☐	☐	
03. Serious reaction to insect bites or food	☐	☐	
04. High Blood Pressure	☐	☐	
05. Hay Fever, Hives, Seasonal Allergies	☐	☐	
06. Heart Disease	☐	☐	
07. Diabetes, Other Endocrine Disorders	☐	☐	
08. Ulcers	☐	☐	
09. Colitis, Irritable Bowel or Crohn's Disease	☐	☐	
10. Shingles (Herpes Zoster)	☐	☐	
11. Renal Disorder	☐	☐	
12. Migraine Headache	☐	☐	
13. Asthma or Other Respiratory Disorder	☐	☐	
14. Seizure or Other Neurological Disorder	☐	☐	
15. Menstrual Cycle Disorder	☐	☐	
16. Does the patient smoke?	☐	☐	
17. Serious Head Injury	☐	☐	
18. Past Surgical History	☐	☐	

PHYSICAL EXAM	Normal: yes	no	Describe Abnormality
19. Skin (including Acne)	☐	☐	
20. Lymph Nodes	☐	☐	
21. Eyes	☐	☐	
22. Ears	☐	☐	
23. Nose, Throat, Teeth	☐	☐	
24. Neck, Thyroid	☐	☐	
25. Chest, Breast, Lungs	☐	☐	
26. Heart Rate /Rhythm (list number)	☐	☐	
27. Heart Size/Murmur	☐	☐	
28. Abdomen, Liver, Kidneys, Spleen	☐	☐	
29. Hernia	☐	☐	
30. Genitalia	☐	☐	
31. Pelvic /Rectal (if indicated)	☐	☐	
32. Extremities, Back, Spine	☐	☐	
33. Neurological Exam/Psych Status	☐	☐	

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Student's Name _____ YU ID#_____ Date of Birth _____

SPORTS PARTICIPATION

☐ Student is able

☐ Student is able with limitations listed below

☐ Student is not able, with reasons listed below

List any limitations on physical activity: _____

Comment: _____

TREATMENT HISTORY

Are there any medical dietary restrictions? ☐ yes ☐ no

Any history of weight loss/weight gain/anorexia? ☐ yes ☐ no

Does the student have any medical conditions other than listed above? ☐ yes ☐ no

If yes, is the student under treatment for the condition(s)?

Please list medications and daily dosages _____

_____

The applicant ☐ does ☐ does not have a history of emotional, psychological, or psychiatric impairment and ☐ is ☐ is not presently under psychotherapy.

Do you have any recommendations for the medical care of this student? _____

_____

I have known the applicant for _____ year(s). The applicant is in ☐ excellent ☐ good ☐ poor health.

PHYSICIAN'S REPORT

Name of Physician _____ Date _____

Physician's Signature _____

Office Phone Number _____

Physician Initials *(office stamp required)* _____

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