

ID# _____

CERTIFICATE OF IMMUNITY

Select One: TNY-MT TNY/MBM Class of _____

TOURO COLLEGE OF OSTEOPATHIC MEDICINE - MIDDLETOWN

60 Prospect Avenue, Middletown, NY 10940
Telephone: 845-648-1000

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), Mumps Titer 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

Date Applied: _____ Date Read: _____ Induration: _____ ID# _____ 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
60 Prospect Avenue, Middletown, NY 10940
Telephone: 845-648-1000

HEALTH HISTORY FORM – TO BE COMPLETED BY STUDENT

Select One: TNY-MT TNY/MBM Class of _____

TOURO COLLEGE OF OSTEOPATHIC MEDICINE - MIDDLETOWN
60 Prospect Avenue, Middletown, NY 10950 Telephone: (845) 648-1000

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



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 travelling 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 meningococcal 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

Apartment

City

State

Zip

Student's Phone Number