Welcome to The Culinary Institute of America
Greystone Campus!

Physical Examination & Health Information

In order to attend the CIA, it is a requirement to have a physical exam performed within the past year and obtain mandatory vaccinations. This information must be documented on the CIA forms. The completed CIA forms must be submitted no later than 45 days prior to your entry date.

The completed Physical Examination & Health Information packet must be submitted by mail, fax or e-mail. Failure to complete these requirements may result in an academic hold and a $200 non-compliance fee.

The Culinary Institute of America
Student Health Services
1946 Campus Drive
Hyde Park, NY 12538

Fax#: 845-905-4061
E-mail: ciahealthservices@culinary.edu

Please e-mail or call the Student Health Office at 1-800-285-4627 ext. 1261 if you have any questions.

Entry Date: _____/_____/_____

Mandatory Student Requirements:
☐ Tuberculosis (TB) screening questionnaire (page 2).
☐ Statement of Health Insurance (page 5) – mandatory for international students only.
☐ Meningitis vaccination response form (page 6).

Mandatory Healthcare Provider Requirements:
☐ Two MMR vaccine dates or proof of immunity (page 1).
☐ Hepatitis A vaccine dates (page 1).
☐ Hepatitis B vaccine (if student <19 years old) (page 1).
☐ Health Care Provider Tuberculosis Risk Assessment, if warranted* (page 3).
☐ History and Physical Exam: signed and dated by a healthcare provider (page 4).

*See page 2 Tuberculosis (TB) Risk Assessment guidelines for reference.
The Culinary Institute of America  
1946 Campus Drive, Hyde Park, NY 12538  
Part I: Immunization Form

Student’s Name: _______________________________________ Date of Birth: ___/___/___  
(Last)          (First)   (MI)  
Address: ___________________________________________________________________  
(Street - Apt #)   (City)   (State - Zip)

Immunization Record:

CSU Executive Order 803 requires post-secondary students born 01/01/57 or later to show protection against measles, mumps, and rubella. Persons born prior to January 1957 are exempt from this requirement. The first dose of vaccine must be given on or after your first birthday.

OPTION 1: MMR (Measles, Mumps, Rubella)  
MMR #1 ______ /_____/______    Measles titer date __/__/___  
MMR #2 ______/_____/______   Mumps titer date __/__/___  
MMR #3 ______/_____/______   Rubella titer date __/__/___

OPTION 2: Antibody Titers (attach lab reports)  
Measles titer date __/__/___  
Mumps titer date __/__/___  
Rubella titer date __/__/___

Mandatory Hepatitis A vaccine (minimum 6 months apart)  
Hep A #1_____/_____/______  
Hep A #2_____/_____/______  

Mandatory Hepatitis B vaccine (if <19 years old)  
Hep B #1_____/_____/______  
Hep B #2_____/_____/______  
Hep B #3_____/_____/______

Meningitis vaccine

Varicella vaccine:  
Varicella #1 ___/___/______  
Varicella #2 ___/___/______  

Meningitis #1___/___/______ (if #1 given prior to age 16)  
Meningitis #2___/___/______

Tetanus-Diptheria-Pertussis (most recent vaccine/booster)  
Td ___/___/______ or Tdap ___/___/______

Signature or Stamp of Healthcare Provider ____________________________ Date ____________________________

Greystone– Revised 10/4/2019
Part IIa: Mandatory Tuberculosis Risk Assessment

Tuberculosis (TB) Risk Assessment – Student Questions

1. Have you ever had close contact with anyone who was sick with tuberculosis (TB)?
   - Yes
   - No

2. Have you ever had a positive TB skin test?
   - Yes
   - No

3. Have you been an employee, volunteer, or resident in a high-risk setting (e.g. correctional facility, healthcare facility, homeless shelter)?
   - Yes
   - No

4. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please CIRCLE the country).
   - Yes
   - No

5. Have you ever had frequent or prolonged visits (>1 month) to one or more of the countries listed below? (If yes, CIRCLE the country below).
   - Yes
   - No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Arennia
Azerbaijan
Bahamas
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Malta
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
(Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2016. Countries with incidence rates of ≥ 20 cases per 100,000 population

If the answer to all the above questions is NO, no further testing or further action is required.

If the answer is YES to any of the above questions, the CIA requires that a healthcare provider complete a Tuberculosis Risk Assessment (Part IIb, page 3).

Student Signature:__________________________ Date:_____

Guardian Signature (only if student <18 years of age): __________________ Date:_____

Greystone– Revised 10/4/2019
Part Ilb: Health Care Provider Tuberculosis Risk Assessment

Tuberculosis (TB) Risk Assessment – Provider Questions

1. Has the student ever had a positive TB skin test or TB blood test?  
   - Yes  
   - No

2. Does the student have a medical condition associated with increased risk of progressing to TB disease if infected (e.g. HIV infection; head/neck/lung cancer; hematologic disease such as leukemia or Hodgkin’s disease; end stage renal disease; chronic malabsorption)?  
   - Yes  
   - No

3. Is the student a member of a high-risk group?  
   - Yes  
   - No

If all the answers above are NO, student is considered low risk and no further testing is needed.  
If any of the answers above are YES, student is considered high risk and requires further TB screening.

TUBERCULOSIS SCREENING (within past 6 months):

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease?  
(Check all that apply).

- Cough (>3 weeks)
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever (> 1 week)

If no symptoms are checked, proceed to TB skin/blood test.  
If any symptoms are checked, provide documentation of evaluation to exclude active tuberculosis disease (TB testing, chest x-ray, sputum evaluation, as indicated).

<table>
<thead>
<tr>
<th>TB Skin Test (results must be read in 48-72 hours):</th>
<th>Quantiferon Test or T-Spot Test (a copy of the lab report must be provided):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Placed _________</td>
<td>Date obtained__________</td>
</tr>
<tr>
<td>Date Read _________</td>
<td></td>
</tr>
<tr>
<td>Results _______ mm induration</td>
<td>Results ______________</td>
</tr>
<tr>
<td>Interpretation ☐ positive ☐ negative</td>
<td></td>
</tr>
</tbody>
</table>

CHEST X-RAY (REQUIRED IF SKIN OR BLOODTEST IS POSITIVE):

Date _______________ | Result (attach copy of report):  
☐ normal  
☐ abnormal

Treatment/recommendations:

___________________________________________________________________________
___________________________________________________________________________

Healthcare Provider Signature ____________________________  
Date ____________________________

Greystone– Revised 10/4/2019
Part IIIa: Medical History

PAST MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING?

- ADD/ADHD
- Anxiety
- Asthma
- Bipolar Disorder
- Bleeding Disorder
- Cancer
- Concussions
- Depression
- Diabetes
- Digestive Problems
- Eating Disorder
- Fainting
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Seasonal Allergies
- Seizure Disorder
- Skin Disease
- Substance Abuse
- Thyroid Disease
- Tobacco Use
- Other

Food Allergies: ____________________________________________________________

Medication Allergies: _______________________________________________________

Additional Allergies: _______________________________________________________

Past Surgical History: _______________________________________________________

Daily Medications/Dosages: __________________________________________________

Part IIIb: Mandatory Physical Exam

Height: _______ Weight: _______ BP: _______/_______ Pulse: _______

<table>
<thead>
<tr>
<th></th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>H.E.E.N.T.</td>
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<td></td>
<td></td>
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<tr>
<td>Neck/Thyroid</td>
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<tr>
<td>Lymph Glands</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Abdomen</td>
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<td></td>
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<tr>
<td>Back/Extremities</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic/Reflexes</td>
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<tr>
<td>Hearing</td>
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<tr>
<td>Vision</td>
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</tbody>
</table>

Recommendations for Physical Activity: ☐ Unlimited ☐ Limited (please explain): ________________

Healthcare Provider Signature: __________________________ Date of Exam: ________________

Name (or stamp): ___________________________ Phone #: ___________________________

Address: ___________________________ Fax #: ___________________________

Greystone – Revised 10/4/2019
Part IV: Statement of Health Insurance Coverage
(Mandatory only for International Students)

Please attach proof of insurance coverage or copy the front and back of your health insurance card here.

Front:

Back:
Part V: Mandatory Meningitis Vaccination Response Form

California Health and Safety code, Sections 120395-12399 requires that colleges and universities distribute information about meningococcal disease and vaccinations to all students.

I have (check one box and sign below):

☑ had the meningococcal immunization within the past five (5) years. The date of vaccination was ______________.

Note: The Advisory committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least one (1) dose of Meningococcal ACWY vaccine not more than five (5) years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16–23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.

☐ read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine or recommended booster dose. I have decided that I/my child will NOT obtain immunization against meningococcal disease at this time.

Note: The Meningococcal ACWY vaccine is offered at Walgreens, 1685 TRANCAS ST, Napa, CA for $133.99.

___________________________________________________________________
Student Signature         Date

OR

_______________________________________________ __________________________________
For students under 18 years of age, Parent/Guardian Signature    Date

________________________________________________ __________________________________
Print Parent/Guardian Name                  Relationship

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State of California Meningitis Fact Sheet:

What is meningococcal disease?
Meningococcal disease is a severe infection of the bloodstream by the bacteria Neisseria meningitidis. When the lining of the brain/spinal cord become infected, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

Who gets meningococcal disease?
Anyone can get meningococcal disease. The disease occurs more often in people who are: teenagers or young adults, infants <1 year of age, living in crowded settings such as college dormitories or military barracks, traveling to areas outside of the United States such as the “meningitis belt” in Africa, living with a damaged spleen or no spleen or have sickle cell disease, have complement component deficiency, exposed during an outbreak, working with meningococcal bacteria in a laboratory.

How is meningococcal disease spread?
It spreads from person-to-person by coughing or coming into close/lengthy contact with someone who is sick/carrues bacteria. Contact includes kissing, sharing drinks and living together. Up to 1:10 people carry meningococcal bacteria in their nose or throat without getting sick.

What are the symptoms?
Sudden high fever, headache, vomiting, stiff neck, red/purple skin rash, weakness and feeling ill, light sensitivity. 10-15% of those who get meningococcal disease die. As many as 1:5 will have permanent disabilities. Complications include hearing loss, brain/kidney damage, limb amputations.

How soon do the symptoms appear?
The symptoms may appear 3–4 days after a person is infected. It can take up to 10 days to develop symptoms.

Is there treatment?
Early diagnosis is very important. If caught early, meningococcal disease can be treated with antibiotics. Sometimes the infection has caused too much damage for antibiotics to prevent death or long-term problems. Most need to be cared for in a hospital.

What is the best way to prevent meningococcal disease?
Get vaccinated! Vaccines are available for people over 6 weeks of age. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease. All teenagers should receive two doses of vaccine against strains A, C, W and Y (ex: Menactra). The first dose is given at 11 to 12 years of age, and the second dose at 16 years. Teens and young adults can also be vaccinated against the "B" strain, also known as Men B vaccine. Talk to your healthcare provider about whether they recommend vaccine against the "B" strain.

Who should not be vaccinated?
Tell your doctor if you have any severe allergies. Anyone who has ever had a severe allergic reaction to a previous dose of meningococcal vaccine should not get another dose of the vaccine. Anyone who has a severe allergy to any component in the vaccine should not get the vaccine. Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they are better.

What should I do if I or someone I love is exposed? Talk with your healthcare provider as they can prescribe an antibiotic to prevent the disease. Resources: Meningococcal Disease – Centers for Disease Control and Prevention (CDC)  Reviewed 8/2018