Welcome to The Culinary Institute of America at Greystone
Physical Examination & Health Information

It is a requirement for every student to have a **completed** Physical Examination documented on the attached CIA form prior to your **Entry Date of:** _____/_____/______ at The Culinary Institute of America.

The physical exam must include all the information requested on the CIA form, done within **one** year, and be returned to the Student Health Office, **30 days prior to your entry date** along with the mandatory vaccination information.

You will not be permitted to attend classes unless this form is completed and returned with required information.

Therefore, it is **MANDATORY** to have the attached CIA physical examination and vaccination information completed and returned by mail, fax, or e-mail.

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

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

In addition, if your information is not completed you may be subject to a $200.00 charge.

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

The following checklist outlines exactly what is required for you to be in compliance with California and CIA guidelines.

**Required Papers:**
- CIA Physical papers completed, dated, and signed by your physician with address information.
- Statement of Health Insurance – including copy of front and back of insurance card.
- Meningococcal Disease Information Page.

**Required Vaccines/Screening:**
- Two MMR vaccine dates or **copies of blood work** showing immunity.
- **Mandatory** Tuberculosis (TB) screening questionnaire - both pages to be completed and signed.
- **Mandatory** Hepatitis A Vaccine.
- **Mandatory** Meningitis Vaccine for all students up to 23 years of age by the first day of school.
The Culinary Institute of America
1946 Campus Drive, Hyde Park, NY 12538
Student Immunization – Medical Examination Form

Print Or Type Clearly:

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

PART I: California School Immunization Law now requires post-secondary students born
01/01/57 or later to show protection against measles, mumps, and rubella. High school or
medical records with this immunization history are acceptable. Persons born prior to January
1957 are exempt from this requirement.

MANDATORY: MMR (Measles, Mumps, Rubella)
TWO Doses (Both must be given after 1967 AND on or after first birthday)

(1) MM/DD/YY____________________________
(2) MM/DD/YY ______________________________

OR

Attach copies of lab reports for Titers
☐ MEASLES  Date______________  ☐ Immune  ☐ Not Immune
☐ MUMPS  Date______________  ☐ Immune  ☐ Not Immune
☐ RUBELLA  Date______________  ☐ Immune  ☐ Not Immune

MANDATORY: Hepatitis A Vaccination Dates:  Shot #1______________ Shot #2______________
(at least six (6) months apart)

MANDATORY Meningitis Vaccine Date:  Shot Date_________  Shot Date_________
for students up to 23 years of age

Hepatitis B Vaccination Dates (optional)  Shot #1______Shot #2_______Shot #3_______

Childhood Illness/Vaccination dates:
Chicken Pox ______________
Varicella Vaccine(s) ______________ ______________
Tetanus Booster ______________

___________________________________________
(Signature of Physician/NP/PA)  Date
PART II: MANDATORY TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE
(To Be Completed By Student/Patient)

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by all incoming students)

Please answer all of the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No

CIRCLE the country or territory you born in that has a high incidence of active TB disease? □ Yes □ No

Afghanistan  Congo  Iran (Islamic Republic of)  Namibia  Singapore
Algeria  Côte d'Ivoire  Iraq  Nauru  Solomon Islands
Angola  Democratic People's Republic of Korea  Kazakhstan  Nepal  Somalia South Africa
Anguilla  of Angola  Kenya  Nicaragua  South Sudan
Argentina  Democratic Republic of the Congo  Kiribati  Niger  Sri Lanka
Armenia  Democratic Republic of Congo  Kuwait  Nigeria  Sudan
Azerbaijan  Djibouti  Kyrgyzistan  Northern Mariana Islands  Suriname
Bangladesh  Lao People's Democratic Republic  Pakistan  Swaziland
Belarus  Ecuador  Palau  Tajikistan
Belize  El Salvador  Latvia  Thailand
Benin  Equatorial Guinea  Lesotho  Timor-Leste
Bhutan  Eritrea  Libya  Togo
Bolivia (Plurinational State of)  Estonia  Liberia  Trinidad and Tobago
Botswana  Ethiopia  Madagascar  Tunisia
Bosnia and Herzegovina  Fiji  Malawi  Turkmenistan
Botswana  French Polynesia  Malaysia  Tuvalu
Brazil  Gabon  Maldives  Uganda
Brunei Darussalam  Gambia  Mali  Ukraine
Bulgaria  Georgia  Republic of Korea  United Republic of Tanzania
Burkina Faso  Ghana  Marshall Islands  Uruguay
Burundi  Greenland  Mauritania  Uzbekistan
Cabo Verde  Guam  Mauritius  Vanuatu
Cameroon  Guatemala  Mexico  Venezuela
Cambodia  Guinea  Micronesia (Federated States of)
Cameroon (Bilingual State)  Guinea-Bissau  Saint Vincent and the Grenadines
Central African Republic  Chad  Sao Tome and Principe
China  Chadian  Senegal  Spain
China, Hong Kong SAR  Haiti  Serbia  Syrian Arab Republic
China, Macao SAR  Honduras  Seychelles  Tajikistan
Colombia  India  Somalia  Turkey
Comoros  Indonesia  South Africa  Turkmenistan


Have you had frequent or prolonged visits to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) □ Yes □ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? □ Yes □ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? □ Yes □ No

Student Signature: ___________________________  Date: __________

Part II: Mandatory Health Care Provider Clinical Assessment

Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes _____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes _____ No _____

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Part II: Continued – Health Care Provider Mandatory Clinical Assessment

Name____________________________________  DOB________________

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes__ No__

If yes, check below:

☐ Cough (especially if lasting for three (3) weeks or longer) with or without sputum production
☐ Coughing up blood (hemoptysis)
☐ Chest pain
☐ Loss of appetite
☐ Unexplained weight loss
☐ Night sweats
☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: ________ mm of induration          **Interpretation:  positive____ negative____

**Interpretation guidelines

>5 mm is positive:

 Recent close contacts of an individual with infectious TB
 persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
 organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
 HIV-infected persons

>10 mm is positive:

 recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
 injection drug users
 mycobacteriology laboratory personnel
 residents, employees, or volunteers in high-risk congregate settings
 persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

 persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method)    QFT-GIT    T-Spot    other_____
M D Y

Result: negative___      positive___     indeterminate___     borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____   Result: normal____ abnormal_____
M D Y

Treatment/Comments:_____________________________________________________________________

______________________________________________________________________________________

Health Care Professional Signature                                                            Date

______________________________________________________________________________________

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PART III: PHYSICAL EXAMINATION (PLEASE COMPLETE ALL INFORMATION)

Vital Signs:
Height:_________ Pulse:_________ Pharynx:_________ Lungs:_________
Weight:_________ Eyes:_________ Thyroid:_________ Abd:_________
B/P:_________ Ears:_________ Heart:_________ Neuro:_________

Extremities/Muscular:________________________________________________________________________________________

1. Medical/Chronic Condition Diagnosis: ________________________________________________________________

____________________________________________________________________________

Asthma_________________ Diabetes________________ Heat Illness_____________
Bleeding Disorders________ Epilepsy/Seizures________ Hypertension____________
Cardiac Problems_________ Frost Bite________________ Thyroid_________________
Concussions_____________

2. List hospitalizations or surgeries: ________________________________________________________________

3. List of medication(s): ____________________________________________________________________________

4. Allergies:

Food Allergies:____________________________________________________________________________________

Medication Allergies:________________________________________________________________________________

Environmental Allergies:____________________________________________________________________________

Circle Yes or No: Allergy to Bee Stings: Yes/No  Allergy to Latex: Yes/No  Carries Epi Pen: Yes/No

Does the student smoke? Yes/No - How much and for how long?___________________________________________

Does the student drink alcohol? Yes/No - How much and for how long?_____________________________________

Does the student use drugs? Yes/No - What and for how long?_____________________________________________

Does the student have any impairment, physical, mental or medical, which would require special
accommodations? ______________________________________________________________________________________

Additional Information___________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

(Signature of Physician/NP/PA) (Please Print Name)

____________________________________________________________________________________________

(Address of Physician) Street City State Zip

(Phone Number): Area Code + Number Date of Examination

ALL PHYSICAL EXAMINATION PAPERWORK IS KEPT CONFIDENTIAL.
STATEMENT OF HEALTH INSURANCE COVERAGE

This form **MUST** be completed, signed and returned with your required medical forms. Incomplete, misleading or false statements may subject you to rejections of any insurance claim, disciplinary actions, or prosecution by civil authorities under applicable laws.

Student Printed Name: __________________________________

Please check one box below:

Do you currently have health insurance?

☐ Yes (You must provide a copy of both front and back of insurance card).

☐ No

Student Signature: ____________________________________________

Permanent/Home Address: _______________________________________

(Street)

(City) (State) (Zip)
Meningococcal Disease
Information for College Students and Parents of Children at Residential Schools and Overnight Camps.

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) caused by the meningococcus germ.

Who gets meningococcal disease?
 Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshman living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, 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.

What are 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 2–10 days after exposure, but usually within five (5) 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, safe and effective vaccines are available (Menactra, Menveo, Menomune). The vaccine is 85% or 100% effective in preventing four kinds of the meningococcus germ (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States.

Is the vaccine safe? Are there adverse side effects to the vaccine?
The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

What is the duration of protection from the vaccine?
After vaccination, immunity develops with 7–10 days and remains effective for approximately 3–8 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals and a booster may be required.

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 website of the California Department of Health, www.dhs.ca.gov; the Centers for Disease Control and Prevention www.cdc.gov/ncidod/diseases/index.htm; and the American College Health Association, www.acha.org. Last reviewed: June 2011

California State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or least four (4) semester hours per quarter, complete and return the following form to The Culinary Institute of America.

Check one box and sign below.
I have (for students under the age of 18: My child has):

☐ Read, or have had explained to me, the information regarding meningococcal meningitis disease. Vaccine date listed on student immunization page.

☐ Read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis within 30 days of admission to the CIA.

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

Print __________________ Signature______________________ Date __________________
(Student)