

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

It is a requirement for every student to have a **Physical Examination** documented on the attached **CIA** form prior to Registration Day 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 documentation.

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.

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

Fax#: 845-905-4061

E-mail: ciahealthservices@culinary.edu

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.

Entry Date: / /

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

Required Papers:

- CIA Physical papers completed, dated, and signed by your physician with address information.**
- Consent for Treatment and Services form.**
- Statement of Health Insurance – including copy of front and back of insurance card.**

Required Vaccines/Screening:

- Two MMR vaccine dates or copies of blood work showing immunity.**
- Mandatory Hepatitis A Vaccine (if left blank the CIA Health Services will administer for a fee).**
- Mandatory Meningitis Vaccine form stating vaccination status (check one option).**
- Mandatory Tuberculosis (TB) screening questionnaire.**

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: NYS Public Health Law 2165 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

<input type="checkbox"/> MEASLES	Date _____	<input type="checkbox"/> Immune	<input type="checkbox"/> Not Immune
<input type="checkbox"/> MUMPS	Date _____	<input type="checkbox"/> Immune	<input type="checkbox"/> Not Immune
<input type="checkbox"/> RUBELLA	Date _____	<input type="checkbox"/> Immune	<input type="checkbox"/> Not Immune

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

Hepatitis B Vaccination Dates (**optional**) Shot #1 _____ Shot #2 _____ Shot #3 _____

Meningitis Vaccine Date (**optional**) Shot Date _____

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

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 _____

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 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

Patients Name: _____ Date of Birth _____

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)

The Culinary Institute of America

Student Health Services

The Culinary Institute of America Student Health Services provides accessible, confidential, quality medical care and health education to our diverse student population.

As college medical professionals knowledgeable about developmental issues, we work with students in promoting their physical, social, and psychological well-being. Our department collaborates with the larger college community, supporting students in accomplishing their educational goals. We believe that an interdisciplinary, coordinated approach delivers optimal care.

We respect your right to confidential, quality care.

Our guidelines for protecting your confidentiality are as follows:

1. Medical records are maintained securely within the health services department.
2. No medical information is shared outside of the department without your consent. The only exception to this would be in situations where it is mandated by law.
3. Information relevant to your care may be shared, on a "need to know" basis, among Health Services Registered Nurses staff (only) or emergency services personnel.
4. Medical records are not part of a student's transcript or college record.

Informed Consent for Treatment and Services

(Student Name)

I, _____, grant permission to The Culinary Institute of America, the Physicians, the Physician Assistant, Nurse Practitioner, and the Registered Nursing staff to review my medical forms and administer such medical, diagnostic, rehabilitative treatments, medications, injections, vaccines (Hepatitis A, Hepatitis B, MMR, Meningococcal immunizations, Gardasil (HPV), tuberculosis test/PPD) and procedures which, in their judgment are deemed necessary or advisable. However, should any specific procedure over and above the routine be necessary, I will be informed of its nature and extent. I acknowledge that in an emergency situation, the Institute will make provisions for emergency services through local hospital and urgent care treatment centers.

My signature below indicates that I have read and understood this informed consent.

Student

Date

Under 18 years old, Parent or Guardian

Date

FILL OUT AND RETURN WITH COMPLETED MEDICAL EXAMINATION FORM

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Communicable Disease Control

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 most common in infants less than one year of age and people 16–21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk. About 1,000–1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10–15% of these people die. Of those who live, another 11–19% lose their arms or legs, have problems with their nervous systems, become deaf or mentally retarded, or suffer seizures or strokes.

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?

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it.

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 New York State Department of Health, www.nyhealth.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: October 2011.

New York 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):

- Had meningococcal immunization within the past five (5) years. The vaccine record is listed on the immunization page. [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 meningitis disease. I (my child) will obtain immunization against meningococcal meningitis **within 30 days** from ____ my private health care provider or ____ the CIA for a fee.
- 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 (my child) will **not** obtain immunization against meningococcal meningitis disease.

Print _____ Signature _____ Date _____
(Student or Parent/Guardian if student is a minor)