Welcome to the Culinary Institute of America
Hyde Park 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.
☐ Consent for Treatment and Services and Consent to Release Health Information (page 6).
☐ Meningitis vaccination response form (page 7).

Mandatory Healthcare Provider Requirements:

☐ Two MMR vaccine dates or proof of immunity (page 1).
☐ Hepatitis A vaccine dates (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

<table>
<thead>
<tr>
<th>Student’s Name: ____________________________</th>
<th>Date of Birth: <em><strong>/</strong></em>/___</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>(MI)</td>
<td>(Street - Apt #)</td>
</tr>
<tr>
<td>(City)</td>
<td>(State - Zip)</td>
</tr>
</tbody>
</table>

Are you one of the following?: __ Veteran  __ Active Military Service Member  __  Military Dependent

NYS Public Health Law 2165 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.

## Required Immunizations

<table>
<thead>
<tr>
<th>OPTION 1: MMR (Measles, Mumps, Rubella</th>
<th>Covid Vaccine – <em>Please submit after fully vaccinated</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR #1 <em><strong><strong>/</strong></strong></em>/______</td>
<td>COVID #1_____/_<strong><strong>/</strong></strong>__</td>
</tr>
<tr>
<td>MMR #2 <em><strong><strong>/</strong></strong></em>/______</td>
<td>COVID #2_____/_<strong><strong>/</strong></strong>__</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTION: 2: Antibody Titers (attach lab reports)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles titer date <em><strong>/</strong></em></td>
<td>Lab report attached</td>
</tr>
<tr>
<td>Mumps titer date <em><strong>/</strong></em></td>
<td>Lab report attached</td>
</tr>
<tr>
<td>Rubella titer date <em><strong>/</strong></em></td>
<td>Lab report attached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hepatitis A vaccine (minimum 6 months apart)</th>
<th>Varicella Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep A #1 <em><strong><strong>/</strong></strong></em>/______</td>
<td>Varicella #1_____/_<strong><strong>/</strong></strong>__</td>
</tr>
<tr>
<td>Hep A #2 <em><strong><strong>/</strong></strong></em>/______</td>
<td>Varicella #2_____/_<strong><strong>/</strong></strong>__</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccines (most recent vaccine/booster)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus Diphtheria Pertussis</td>
</tr>
<tr>
<td>Td_____/<em><strong><strong>/</strong></strong>__ or Tdap</em>___________</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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**Signature or Official Stamp of Healthcare Provider**  
**Date**

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**Hyde Park – Revised 6/8/2021**
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
Armenia
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
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Georgia
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
Mali
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: ______

Hyde Park – Revised 6/8/2021
Part IIb: 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 _________             Date Read __________</td>
<td>Date obtained____________</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 _______________________

Hyde Park – Revised 6/8/2021
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:_________

NORMAL  ABNORMAL  COMMENTS

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

Recommendations for Physical Activity:  
- Unlimited
- Limited (please explain):___________________
______________________________________________________________________________

Healthcare Provider Signature:____________________________   Date of Exam:_______________

Name (or stamp)________________________________________   Phone #:____________________

Address________________________________________________  Fax #:_______________________

Hyde Park – Revised 6/8/2021
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: Informed Consent for Treatment and Services and Consent to Release Health Information

I, ________________________________, grant permission to The Culinary Institute of America, the 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, 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 Signature       Date

OR

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

Print Parent/Guardian Name      Relationship

Please Complete This Section:

My signature below indicates that I authorize the release of non-sensitive STUDENT HEALTH INFORMATION (not including information related to ALCOHOL and/or DRUG TREATMENT, MENTAL HEALTH TREATMENT, and/or CONFIDENTIAL HIV/AIDS-RELATED INFORMATION) as follows:

BY: Health Services, The Culinary Institute of America (CIA), 1946 Campus Drive, Hyde Park, NY 12538

TO: ______________________________________(Contact Person) ________________________ (Relationship)

Contact Phone Number:_________________________________________________________________

Contact Address:  _______________________________________________________________________

_____________________________________________________________________________________
___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Student Signature (required if over 18 years of age)     Date

Hyde Park – Revised 6/8/2021
Part VI: Mandatory Meningitis Vaccination Response Form

New York State Public Health Law 2167 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 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 the CIA Student Health Services Office for $120.00.*

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 **NYSDOH Meningococcal Disease 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/carries 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 felling 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 MenB 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)](https://www.cdc.gov/meningococcal/)

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Hyde Park – Revised 6/8/2021