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

Student's Name: _____Date of Birth: ___/___/___
(Last) (First) (MI)
Address: _____
(Street - Apt #) (City) (State - Zip)

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

Required Immunizations:

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.

OPTION 1: MMR (Measles, Mumps, Rubella)

MMR #1 _____ /_____/_____
MMR #2 _____/_____/_____

OPTION: 2: Antibody Titers (attach lab reports)

Measles titer date__/__/___ ❑ Lab report attached
Mumps titer date __/__/____❑ Lab report attached
Rubella titer date ___/__/___❑ Lab report attached

Mandatory Hepatitis A vaccine (minimum 6 months apart)

Hep A #1____/____/___
Hep A #2____/____/___

Optional Hepatitis B vaccine:

Hep B #1 ____/____/____
Hep B #2 ____/____/____
Hep B #3 ____/____/____

Varicella vaccine:

Varicella #1 ___/___/____
Varicella #2 ___/___/____

Meningitis vaccine

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

Tetanus-Diptheria-Pertussis (most recent vaccine/booster)

Td ___/___/____ **or** Tdap ___/___/____

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

Name_____ Date of birth_____

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

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 10/4/2019

Name_____ Date of birth_____

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).

TB Skin Test (results must be read in 48-72 hours): Date Placed _____ Date Read _____ **Results** _____ mm induration **Interpretation** ❑ positive ❑ negative	**Quantiferon Test or T-Spot Test** (a copy of the lab report **must** be provided): Date obtained_____ **Results** _____

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 10/4/2019

Name:_____ Date of birth_____

Part IIIa: Medical History

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

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

Food Allergies:_____

Medication Allergies:_____

Additional Allergies:_____

Past Surgical History:_____

Daily Medications/Dosages:_____

_____

Part IIIb: Mandatory Physical Exam

Height:_____ Weight:_____ BP:_____/_____ Pulse:_____

	NORMAL	ABNORMAL	COMMENTS
Skin			
H.E.E.N.T.			
Neck/Thyroid			
Lymph Glands			
Lungs			
Cardiovascular			
Abdomen			
Back/Extremities			
Neurologic/Reflexes			
Hearing			
Vision			

Recommendations for Physical Activity: ❑ Unlimited ❑ Limited (please explain):_____

_____

Healthcare Provider Signature:_____ Date of Exam:_____

Name (or stamp)_____ Phone #_____

Address_____ Fax #_____

Name:_____ Date of birth_____

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:

Name:_____ Date of birth_____

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**

Name:_____ Date of birth_____

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 <u>one</u> 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 **<u>NOT</u>** 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.

_____

Student Signature Date

OR

_____

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

_____

Print Parent/Guardian Name Relationship

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: <u>Meningococcal Disease – Centers for Disease Control and Prevention</u> (CDC) *Reviewed 8/2018*