Welcome to The Culinary Institute of America
San Antonio 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 30 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 will 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: __/____/____

Requirements:

- Mandatory Meningococcal Vaccination/Booster if < 22 years of age (page 1)
- Mandatory Hepatitis A Vaccine (page 1)
- Mandatory Tuberculosis (TB) screening questionnaire (pages 2-3)
- Mandatory CIA History and Physical: signed and dated by a healthcare provider (page 4)
- Optional Statement of Health Insurance – mandatory for international students (page 5)
The Culinary Institute of America
1946 Campus Drive, Hyde Park, NY 12538
Part I: Student Immunization Form

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

Immunization Record:

**Mandatory** Meningococcal Vaccination < 22 years of age (within past 5 years)

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

**Mandatory** Hepatitis A vaccine (minimum 6 months apart)

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

Hepatitis B vaccine:

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

MMR (Measles, Mumps, Rubella)

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

Varicella vaccine:

Varicella #1_____/_____/_____
Varicella #2_____/_____/_____

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

Td ____/____/____ or Tdap ____/____/____

________________________________________________________________________
Signature of Healthcare Provider Date
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


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:____________

San Antonio – Revised 010/3/2018
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 ___________________

San Antonio – Revised 010/3/2018
Part IIIa: Mandatory 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
- Thyroid Disease
- Tobacco Use
- Other _______________

Food Allergies: __________________________________________________________

Medication Allergies: __________________________________________________

Additional Allergies: ____________________________________________________

Past Surgical History: __________________________________________________

Daily Medications/Dosages: ______________________________________________

Part IIIb: Physical Exam

<table>
<thead>
<tr>
<th>Height: __________</th>
<th>Weight: __________</th>
<th>BP: <em><strong><strong><strong>/</strong></strong></strong></em></th>
<th>Pulse: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL</td>
<td>ABNORMAL</td>
<td></td>
<td>COMMENTS</td>
</tr>
</tbody>
</table>

| 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 #: ___________________________

San Antonio – Revised 010/3/2018
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: