# *Welcome to The Culinary Institute of America, San Antonio*
# 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.**


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.*

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The following checklist outlines exactly what is required for you to be in compliance with Texas 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.**

**Required Vaccines/Screening:**

- ☐ Two MMR vaccine dates or **copies of blood work** showing immunity.
- ☐ **Mandatory** Tuberculosis (TB) screening questionnaire.
- ☐ **Mandatory** Hepatitis A Vaccine.
- ☐ **Mandatory Meningitis Vaccine** unless:

(1) the student is 22 years of age or older by the first day of school.

(2) An affidavit or certificate signed by a physician who is duly registered and licensed to practice medicine in the United States, stating that in the physician's opinion, the vaccination would be injurious to the health and well-being of the student; or

(3) An affidavit signed by the student stating that the student declines the vaccination for reasons of conscience, including a religious belief. A Conscientious Exemption form from The Texas Department of State Health Services (DSHS) must be used. If a student has an objection to receiving the vaccination for reasons of conscience it is their responsibility to complete the DSHS form, have it notarized and returned to Student Health Services. Information about requesting the affidavit form from DSHS is found at http://www.dshs.state.tx.us/immunize/school/default.shtm#exclusions.

**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: Texas Department of Health 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. Texas minimum state requirements also mandate Meningococcal vaccination by the first date of attendance.**

**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_____

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
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
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
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
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
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
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
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
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 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 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

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_____

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_____ _____

(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.**

**The Culinary Institute of America**

1946 Campus Drive, Hyde Park, NY 12538-1499

***STATEMENT OF HEALTH INSURANCE COVERAGE***

***This form <u>MUST</u> 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)