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 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).
☐ Complete Covid vaccination series and booster, or religious/medical exemption.

Mandatory Healthcare Provider Requirements:
☐ Meningococcal Vaccination/Booster if < 22 years of age (page 1)
☐ Hepatitis A vaccine dates (page 1).
☐ Two MMR vaccine dates or proof of immunity (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.
## Part I: Immunization Form

**Student’s Name:** _____________________________

**Date of Birth:** __/__/__

**Address:**

- **(Street - Apt #)** ___________________________________________
- **(City)** ___________________________________________
- **(State - Zip)** ___________________________________________

### Required Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date(s)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis Vaccine</td>
<td></td>
<td>(mandatory if student is &lt; 22 years of age) given within the past 5 years</td>
</tr>
<tr>
<td>Meningitis #1</td>
<td></td>
<td></td>
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<tr>
<td>Meningitis #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A vaccine (minimum 6 months apart)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep A #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep A #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPTION 1: MMR (Measles, Mumps, Rubella)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR #1</td>
<td></td>
<td></td>
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<tr>
<td>MMR #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPTION 2: Antibody Titers (attach lab reports)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles titer date</td>
<td></td>
<td></td>
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<tr>
<td>Mumps titer date</td>
<td></td>
<td></td>
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<tr>
<td>Rubella titer date</td>
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</tr>
<tr>
<td><strong>COVID Vaccine – Please submit after fully vaccinated</strong></td>
<td></td>
<td></td>
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<tr>
<td>COVID #1</td>
<td></td>
<td></td>
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<tr>
<td>COVID #2</td>
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<tr>
<td>BOOSTER</td>
<td></td>
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</tbody>
</table>

### Optional Immunizations

- **Hepatitis B Vaccine**
- Hep B #1
- Hep B #2
- Hep B #3

- **Varicella Vaccine**
- Varicella #1
- Varicella #2

- **Tetanus Diphtheria Pertussis**
  (most recent vaccine/booster)
  - Td
  - or Tdap

- **Seasonal Flu Vaccine**

- **Waiver Submitted**

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**Signature or Official Stamp 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


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 (if student <18 years of age): __________________________ Date: __________
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 8/11/2022
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:_______

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

Recommendations for Physical Activity: ☐ Unlimited  ☐ Limited (please explain):________________________

Healthcare Provider Signature:__________________________  Date of Exam:__________________________

Name (or stamp)____________________________________  Phone #__________________________

Address____________________________________________  Fax #__________________________

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