YESHIVA UNIVERSITY

STUDENT MEDICAL INFORMATION

ATTENTION YU STUDENT

The Beth Israel Student Health Services Network provides medical services to students on the Wilf and Beren campuses of Yeshiva University. To document your health status—and to ensure that you are compliant with New York State public health law—you must provide a complete immunization record, medical history, and evidence of a recent physical examination. **These documents must be submitted to YU before you can receive your housing assignment and register for classes.** The Health Services Network will communicate to Yeshiva University administrative personnel our assessment of your ability to mentally and physically perform as a student, without restriction and without any immediate or direct threat of harm to yourself or to others. Medical information will be released to others only when and if prescribed by law or with your or your guardian's consent.

Take care to complete every section and answer all questions. Make certain to print your name, date of birth, and YU ID# at the top of each page. If you will be under age 18 when you begin classes at the University, have your parent or guardian read, sign, and date the Parental Permission section on this page. Pages 2–5 should be completed with your physician and should include an update of your immunization records. Your doctor must validate the following forms with his/her signature and an office stamp.

Once you have completed these forms, fax all five pages to the appropriate campus health center, listed at the bottom of this form.

STUDENT INFORMATION

Name ______________________ YU ID# ____________ Date of Birth ________

Home Address ______________________ Place of Birth ______________________

______________________ Home Phone ______________________

City/State/Zip ______________________ Social Security # ______________________

Gender ☐ male ☐ female U.S. Citizen? ☐ yes ☐ no

My Insurance Company ______________________ Date this form was submitted ______________

PARENTAL PERMISSION

The law requires that parental consent be obtained to provide medical treatment, prescribe or dispense medications, or perform procedures on minors (persons under age 18). A parent or legal guardian should sign this consent form so that such treatment may be administered promptly and unnecessary delay avoided. Note: Except in a dire emergency, no operative procedure will be performed without parental notification and additional consent.

I give permission for such diagnostic, therapeutic, or emergency operative procedure as may be necessary to evaluate and treat my son/daughter or person named above for whom I am legal guardian.

Parent/Guardian *(print)* ______________________ Relationship ______________________

Parent/Guardian *(sign)* ______________________ Date ______________________

Ask your health care provider to validate the information with a signature and office stamp. Return the completed packet by fax (and without a cover page) to your campus health center listed below. For additional information, please contact:

Student Health Center
Wilf Campus (Men)
116 Laurel Hill Terrace
New York, NY 10033
Phone 646-685-0391
Fax 646-685-0395

Student Health Center
Beren Campus (Women)
50 East 34th Street, Room 2B
New York, NY 10016
Phone 212-340-7792
Fax 212-340-7858

DOCTOR: PLEASE FAX THIS PAGE TO THE APPROPRIATE CAMPUS HEALTH CENTER:
Wilf Campus (Men) fax: 646-685-0395 Beren Campus (Women) fax: 212-340-7858

In order to maintain the health of all students: New York State public health law requires that students attending postsecondary institutions in the state submit proof of immunization against certain vaccine preventable diseases. YU students may demonstrate immunity by presenting proof of having received two vaccinations for Rubeola (Measles), two vaccinations for Mumps, and at least one vaccination for Rubella (German Measles) or if given in combination, two M-M-R (Measles, Mumps and Rubella) vaccines. Immunity may also be affirmed by providing the results of a laboratory test (immune titer) for each disease.

Student's Name ______________________ YU ID# ____________ Date of Birth ________

MANDATORY IMMUNIZATIONS

Two Measles Mumps and Rubella (MMR) vaccinations

Date 1: Immunization on or after first birthday and after January 1, 1957 — Date ____________

Date 2: Immunization 15 months after birth and at least 28 days after 1st vaccination — Date ____________

If born **before** 1957, indicate birth date — Date of Birth ________

OR

Two Measles (Rubeola) vaccinations

Date 1: Immunization on or after first birthday and after January 1, 1957 — Date ____________

Date 2: Immunization 15 months after birth and at least 28 days after 1st vaccination — Date ____________

Date of positive immune titer — Date ____________

Rubella (German Measles) vaccination

Date 1: Immunization on or after first birthday and after January 1, 1957 — Date ____________

Date 2: Immunization 15 months after birth and at least 28 days after 1st vaccination — Date ____________

Date of positive immune titer — Date ____________

Two Mumps vaccinations

Date 1: Immunization on or after first birthday and after January 1, 1957 — Date ____________

Date 2: Immunization 15 months after birth and at least 28 days after 1st vaccination — Date ____________

Date of positive immune titer — Date ____________

Physician Initials *(office stamp required)* ________________________________

Note: While meningitis vaccination is recommended by the NYS Departmenet of Health but is not mandatory, a completed Meningitis Vaccination Response form (see below) must be submitted by every student.

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours or the equivalent per semester, or at least four semester hours per quarter, must complete and return this form.

COMPLETE THE INFORMATION SECTION BELOW; CHECK ONE RESPONSE BOX, SIGN AND DATE

I have:

☐ had the Meningococcal Meningitis immunization (Menomune™ or Menactra™) within the past 10 years.

Date received ________________

☐ read the information regarding Meningococcal Meningitis, available on the Web at
http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm, **or**
http://www.health.state.ny.us/nysdoh/communicable_diseases/en/menin.htm, **or**
http://www.cdc.gov/nip/publications/vis/vis-mening.pdf.

I will obtain immunization against Meningococcal Meningitis within 30 days from my private health care provider or through the Beth Israel Student Health Services Network at Yeshiva University.

☐ read the information regarding Meningococcal Meningitis, available on the Web at
http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm, **or**
http://www.health.state.ny.us/nysdoh/communicable_diseases/en/menin.htm.

I understand the risks of not receiving the vaccine. I have decided I will **not** obtain immunization against Meningococcal Meningitis.

Signature ______________________________ Date ____________________
Student (if 18 years or older), otherwise parent

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Wilf Campus (Men) fax: 646-685-0395 Beren Campus (Women) fax: 212-340-7858

STUDENT MEDICAL INFORMATION *Additional immunization history*

Student's Name ______________________ YU ID# ____________ Date of Birth ________

OTHER VACCINES (RECOMMENDED BUT NOT MANDATORY FOR ADMISSION)

Tetanus, Diphtheria, Pertusis (primary series completed) Date ____________

Last booster (within 10 years) Date ____________

Hepatitis A Series First ____________ Second ____________

Hepatitis B Series First ____________ Second ____________ Third ____________

Varicella (Chicken Pox) Vaccine Date ____________

Positive immune Titer to Varicella Date ____________

OR

Date Varicella was diagnosed Date ____________

Polio (If primary series completed, list the last booster) Date ____________

OTHER TESTS (NOT MANDATORY FOR ADMISSION)

Tuberculosis skin test Date ____________ Result: ☐ neg ☐ pos

If positive, date of chest X-ray Date ____________ Result: ☐ neg ☐ pos

If positive, was prophylaxis given? ☐ yes ☐ no Dates: from ____________ to ____________

Name of Physician ______________________ Date ____________

Physician's Signature ______________________

Physician Stamp *(office stamp required)* ______________________

Student's Name ______________________ YU ID# __________ Date of Birth __________

Height ________ Weight ________ BP ________ Pulse ________ Hearing: normal ☐ yes ☐ no

Vision: Right 20/ _____ Left 20/ _____ ☐ With glasses or contacts Color vision: normal ☐ yes ☐ no

SYSTEMS REVIEW	yes	no	Describe Abnormality
01. Loss or impaired function of any organ	☐	☐	____________
02. Allergic to medications	☐	☐	____________
03. Serious reaction to insect bites or food	☐	☐	____________
04. High Blood Pressure	☐	☐	____________
05. Hay Fever, Hives, Seasonal Allergies	☐	☐	____________
06. Heart Disease	☐	☐	____________
07. Diabetes, Other Endocrine Disorders	☐	☐	____________
08. Ulcers	☐	☐	____________
09. Colitis, Irritable Bowel or Crohn's Disease	☐	☐	____________
10. Shingles (Herpes Zoster)	☐	☐	____________
11. Renal Disorder	☐	☐	____________
12. Migraine Headache	☐	☐	____________
13. Asthma or Other Respiratory Disorder	☐	☐	____________
14. Seizure or Other Neurological Disorder	☐	☐	____________
15. Menstrual Cycle Disorder	☐	☐	____________
16. Does the patient smoke?	☐	☐	____________
17. Serious Head Injury	☐	☐	____________
18. Past Surgical History	☐	☐	____________

PHYSICAL EXAM	Normal: yes	no	Describe Abnormality
19. Skin (including Acne)	☐	☐	____________
20. Lymph Nodes	☐	☐	____________
21. Eyes	☐	☐	____________
22. Ears	☐	☐	____________
23. Nose, Throat, Teeth	☐	☐	____________
24. Neck, Thyroid	☐	☐	____________
25. Chest, Breast, Lungs	☐	☐	____________
26. Heart Rate /Rhythm (list number)	☐	☐	____________
27. Heart Size/Murmur	☐	☐	____________
28. Abdomen, Liver, Kidneys, Spleen	☐	☐	____________
29. Hernia	☐	☐	____________
30. Genitalia	☐	☐	____________
31. Pelvic /Rectal (if indicated)	☐	☐	____________
32. Extremities, Back, Spine	☐	☐	____________
33. Neurological Exam/Psych Status	☐	☐	____________

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Student's Name ______________________ YU ID#__________ Date of Birth__________

SPORTS PARTICIPATION

☐ Student is able

☐ Student is able with limitations listed below

☐ Student is not able, with reasons listed below

List any limitations on physical activity: ______________________

Comment: ______________________

TREATMENT HISTORY

Are there any medical dietary restrictions? ☐ yes ☐ no

Any history of weight loss/weight gain/anorexia? ☐ yes ☐ no

Does the student have any medical conditions other than listed above? ☐ yes ☐ no

If yes, is the student under treatment for the condition(s)?

Please list medications and daily dosages ______________________

____

The applicant ☐ does ☐ does not have a history of emotional, psychological, or psychiatric impairment
and ☐ is ☐ is not presently under psychotherapy.

Do you have any recommendations for the medical care of this student? ______________________

____

I have known the applicant for ________ year(s). The applicant is in ☐ excellent ☐ good ☐ poor health.

PHYSICIAN'S REPORT

Name of Physician ______________________ Date __________

Physician's Signature ______________________

Office Phone Number ______________________

Physician Stamp (*office stamp required*) ______________________

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