ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI MEDICAL STATUS FORM

Student's name:_____

To be completed by student:

Do you have any illness that may interfere with your ability to work on a clinical service?

Yes [ ] No [ ] If yes, specify:

_____

_____

To be completed by the medical provider:

1.Physical exam : within 12 months of school's start

1. Screening for Tuberculosis

a) For students with a previously negative PPD: PPD (not Tine test) within 6 months of the elective's start is required.

PPD planted Date:_ month/day/year_____

PPD read Date:_month/day/year_____ Results: _____mm Interpretation: Positive[ ] Negative[ ]

b) For students with a history of positive PPD: Chest x-ray within 6 months of the elective's start is required.

Chest x-ray Date: month/day/year_____ Interpretation:_____

Copy of the x ray result must be submitted.

c) For students with PPD conversion in the last 12 months: Chest x-ray within 6 months of the elective's start, proof of medication for latent tuberculosis and provider's attestation of absence of disease are required.

Chest x-ray Date: month/day/year_____ Interpretation:_____

Copy of the x ray result must be submitted.

Medication(s): Name(s)and Dosage(s)_____ Dates taken:_month/day/year_____

I attest that the student is free of symptoms: haemoptysis, cough, fever, night sweats, weight loss.

Initials of medical provider: _____

2. Titers and vaccines: COPY OF THE LAB REPORT TITERS WITH NUMERIC VALUES ARE REQUIRED.

Measles	Mumps	Rubella	Varicella**	Hepatitis B	TDaP*
[] Immune	[] Immune	[]Immune	[]Immune	[]Immune	--------
[]Not immune	[]Not immune	[]Not immune	[]Not immune	[]Not immune	--------
If not immune, dates of vaccines					
Measles or MMR Dates: Month/day/year 1. 2.	Mumps or MMR Dates: Month/day/year 1. 2.	Rubella or MMR Dates: Month/day/year 1. 2.	Dates: Month,day,year 1. 2.	Dates: Month,day, year 1. 2. 3.	Date: Month,day, year 1.

***If Td only was given, the student needs a dose of TDaP. No titers are required.**

**** Varicella titers are required even if the student had the disease.**

In compliance with the New York Health Code, I examined the above student. He/she is free from any health or behavioral issues I attest that the above information is true.

Name:_____Signature:_____Date:_month/day/year_____

Address/phone/email:_____