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. e e e e a e e ve g a g e a eg e a e The Health Services Network will communicate to Yeshiva University administrative personnel

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 e e 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, http://www.health.state.ny.us/nysdoh/communicable_diseases/en/menin.htm,

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

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)* _____

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

YESHIVA UNIVERSITY

STUDENT MEDICAL INFORMATION *Medical status*

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

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

STUDENT MEDICAL INFORMATION *Medical status (continued)*

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*)exia? q9542.9531 Tm0 0 0 1 k0.026 Tw(ea.4531 Tm1icant is in qdBcant ism23 Tf8 RR15o.91878 lS165.50oi k0.0

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