2017 P&S Visiting Student Immunization Form

Students: Failure to complete the following form in its entirety will result in a denial of your application. Items **3**, **6**, and **8** must be completed within 12 months of the desired rotation. *For example: To be offered an October 2017 rotation, you must have received a Hep C titer (#3), PPD/Chest Xray (#6), and Physical (#8) after October 31, 2016.*

Once all sections are complete, please fax to:
P&S Office of Medical Education, Attn: Brooke Rawson, Fax #: 212-305-0720

DO NOT fax additional health records unless explicitly asked. Faxed records will not be verified over the phone.

	To be completed by a clinician or health care official.		
	Student Name:		**Date:**
1	**Measles, Mumps, Rubella**		
	Positive titers for Measles, Mumps and Rubella required for all students. A third MMR shot is required only if any MMR titers not positive.		**Circle One**
	Measles Titer (IgG)	Date:	Pos or Neg
	Mumps Titer (IgG)	Date:	Pos or Neg
	Rubella Titer (IgG)	Date:	Pos or Neg
	MMR #1 _______________ (date)	**MMR #2** ________________ (date)	**MMR #3** ______________ (date)
2	**Hepatitis B Immunity**		
	Hepatitis B series and post-immunization titer required for all students. If titer is negative after Hep B 4, 2 additional Hep B vaccines are required with a Hep B titer 30 days after the last Hep B.		
	Hepatitis B #1	Date:	
	Hep B #2	Date:	
	Hep B #3	Date:	**Circle One**
	Post-immunization Hep B Surface Antibody (IgG)	Date:	Pos or Neg
	Hep B Surface Antigen *Required only if Hep B post-immunization titer is Neg.*	Date:	Pos or Neg
	Hep B #4 *Required only if Hep B Surface Antibody and Antigen are Neg.*	Date:	
3	**Hepatitis C Antibody** **MUST BE WITHIN 12 MONTHS OF ROTATION**		
			Circle One
	Hepatitis C titer	Date:	Pos or Neg
4	**Varicella Immunity**		
	Varicella Disease (Clinician verified)	Yes or No	**Circle One**
	Varicella Titer (IgG) *Perform only if there is a history of varicella disease. If Varicella Antibody after disease is negative, indicate 2 doses of Varicella vaccine below.*	Date:	Pos or Neg
	Varicella Vaccine #1	Date:	
	Varicella Vaccine #2 *Must be 30 days after Dose 1.*	Date:	

CUMC College of Physicians and Surgeons
104 Have Avenue, Suite 1103, New York, NY 10032
Psvisitingstudents@cumc.columbia.edu | P: 212-305-3806 | F: 212-305-0720

5	Tetanus Immunity		
	Must be within 10 years.		**Circle One**
	Most recent Td booster	Date:	Td or Tdap

6	Tuberculosis Testing **MUST BE WITHIN 12 MONTHS OF ROTATION**		
	Please complete #1 or #2.		
	#1 PPD *Should be placed even with a history of BCG administration.*		
	PPD placed	Date:	
	PPD read	Date:	
	Induration	_______________mm	
	#2 Quantiferon Gold or **TB Spot (*Circle Which*)**		
	Date of Quantiferon Gold or Tb Spot:		Pos or Neg
	If PPD is >10 mm (5 mm if HIV+ or recent contact) or if Quantiferon Gold/TB Spot is positive, please answer the following questions. Does student have:		
	Cough?	Yes or No	
	Night sweats?	Yes or No	
	Weight Loss?	Yes or No	
	History of BCG?	Yes or No	*If Yes, year given:*
	Treatment with INH?	Yes or No	*If yes, from (mo-yr) to (mo-yr)*
	Chest X-Ray *Required at medical school entry if PPD positive at that time; otherwise within one year of rotation date.* *Attach CXR report.*	Date:	Pos or Neg

7	Respirator Mask ***International students may complete this at P&S for fee.***	
	Date of Fitting:	
	Specify type of mask (ex: N95):	
	Mask Size:	
	Make/Model:	

8	Physical Examination **MUST BE WITHIN 12 MONTHS OF ROTATION**	
	Date of Exam:	

9	Influenza Vaccination	
	Required for Fall 2017/Winter 2018 rotations. During this time, visiting students without an influenza vaccination will be required to wear a mask in patient areas. Can be left blank if applying for spring/summer months, but students may be required to update upon further notice.	
	Date of vaccination:	

Clinician Signature

I certify that this student is in good health without contraindications to clinical care of patients. **Yes or No**

Signature of Clinician:	
Print Clinician Name:	
Provider ID:	
Date:	