COLUMBIA | COLUMBIA UNIVERSITY IRVING MEDICAL CENTER
STUDENT HEALTH ON HAVEN

Pre-Registration Immunization Form for Clinical Students: 2022-2023 Academic Year

This form must be completed by an MD/DO, NP, or PA who is not a relative. Attach physical exam, immunization records, and **copies of all laboratory and x-ray reports**. You must submit all reports in English; failure to do so will result in registration delays. All items are required as written below. **Only this form will be accepted as proof of immunization.**

Visit the **Student Health on Haven website** for additional information on pre-registration health requirements for clinical students.

This section to be completed by the student:

Last Name		**First Name**		**Middle Initial**	
UNI		**Date of Birth**		**School/Program**	
Full-time	◯	**Part-Time**	◯	**Telephone Number**	

This section to be completed by a medical provider:

Hepatitis B: *Documentation of **complete** Hepatitis B series **AND** a positive **quantitative** Hepatitis B surface antibody titer at least 30 days after last dose **AND** Hepatitis B surface antigen. Visit **www.cdc.gov/vaccines/vpd/hepb/hcp/** for additional information.*

Option A

Hepatitis B vaccine, Hepatitis B surface antibody titer>10 mIU/mL, and Hepatitis B antigen titer

If you completed the Hepatitis B series and your titer is <10 mIU/mL one to two months after your last vaccine, you will require additional doses.

Also, submit the date of the previous immunizations and negative/non-reactive titer. If you have already received two full courses of Hepatitis B vaccination, submit the dates of ALL doses of vaccine and negative titers.

Vaccine	Date	Vaccine *(if necessary)*	Date
Heplisav-B			
Dose 1		Dose 3 *(if necessary)*	
Dose 2		Dose 4 *(if necessary)*	
OR			
Engerix-B or Recombivax-HB			
Dose 1		Dose 4 *(if necessary)*	
Dose 2		Dose 5 *(if necessary)*	
Dose 3		Dose 6 *(if necessary)*	
AND			
Titer	**Date**	**Result**	**Copy Attached**
Hepatitis B Surface Antibody Quantitative			**Lab Report Required**
Hepatitis B Surface Antigen			**Lab Report Required**

Option B
History of Hepatitis B infection

If BOTH of these titers are negative you should be immunized and check the surface antibody titer one to two months after last dose of vaccine

Hepatitis B Core Antibody Quantitative*			**Lab Report Required**
Hepatitis B Surface Antigen titer*			**Lab Report Required**

**** Within Six Months of Start Date***

Name_____UNI _____

Hepatitis C: *Hepatitis C antibody within 6 months of program start date (lab report required). If hepatitis C antibody is positive, a quantitative hepatitis C RNA test is required.*				
	Titer	**Date**	**Result**	**Copy Attached**
	Hepatitis C IgG titer			**Lab Report Required**
Only if IgG Positive	Hepatitis C Quantitative RNA			**Lab Report Required**

Measles (Rubeola), Mumps, Rubella (MMR): *Two doses of MMR vaccine **(after first birthday)** OR two doses of measles vaccine, two doses of mumps vaccine, and one dose of rubella vaccine OR positive titers (IgG) showing immunity to measles, mumps and rubella*				
Option A MMR Immunizations *(On or after first birthday and at least 28 days apart)*	**Vaccine/Titer**	**Date**	**Result**	**Copy Attached**
	MMR Dose 1		**N/A**	
	MMR Dose 2			
Option B Positive MMR IgG Antibody titers *(lab reports required)*	Measles (*Rubeola*) Titer			**Lab Report Required**
	Mumps Titer			**Lab Report Required**
	Rubella Titer			**Lab Report Required**
Option C Measles, Mumps and Rubella Immunizations *(On or after first birthday and at least 28 days apart)*	Measles Dose 1		**N/A**	
	Measles Dose 2			
	Mumps Dose 1			
	Mumps Dose 2			
	Rubella Dose 1			

Polio: *Documented date of most recent IPV (killed) or OPV (live) polio vaccine recommended (not required)*				
	Vaccine	**Date**	**Check One**	**Copy Attached**
	Dose		☐ IPV ☐ OPV	**N/A**

Tetanus, Diphtheria, Acellular Pertussis: *One-time dose of Tdap vaccine required regardless of date of last tetanus shot; tetanus boosters every 10 years thereafter*				
	Vaccine	**Date**	**Result**	**Copy Attached**
	Tdap *(required)*		**N/A**	
	Td/Tdap vaccine dose *(if more than 10 years since last Tdap)*			

Name_____ UNI _____

Tuberculosis Screening: *IGRA blood test (QuantiFERON Gold or T-Spot) within 6 months of program start date. If positive, submit chest x-ray report.* ***Only IGRA or T-spot will be accepted; TB skin tests will not be accepted.***

Option A No Prior Positive Test *Documentation of a negative test reported within six months of program start date (lab report required)*	**Test**	**Date**	**Result/Reading**	**Copy Attached**
	IGRA Blood Test (QuantiFERON or T-SPOT):			**Lab Report Required**
Option B History of Prior Positive Test *(recent or past)* ** History of latent TB, positive skin test or positive blood Test* *** Chest x-ray should be dated after the date of the positive test.*	POSITIVE skin test* *(reading > 10 mm)*		mm	**N/A**
	Positive IGRA Blood Test (QuantiFERON or T-SPOT testing)			**Lab Report Required**
	Report	**Date**	**Normal/Abnormal**	**Copy Attached**
	Chest X-ray Report *(required)***			**Report Required**
Prophylactic Medications for Latent TB Taken	**Yes** ☐		**Date Started**	
	No ☐		**Date Ended**	
	Medications Taken			
	Length of Treatment			
Option C History of Active TB *(recent or past)* *** Chest x-ray should be dated after the date of the positive test.*	**Date of Diagnosis**		**Date Treatment Completed**	
	Report	**Date**	**Normal/Abnormal**	**Copy Attached**
	Chest X-ray Report *(required)***			**Report Required**

Varicella: *Two doses of Varicella vaccine* ***(after first birthday)*** *OR positive Varicella IgG antibody titer*

Option A Varicella Immunizations *(two doses required at least 28 days apart)*	**Vaccine/Titer**	**Date**	**Result**	**Copy Attached**
	Dose 1		**N/A**	**N/A**
	Dose 2			
Option B Positive Varicella IgG Antibody titer	Varicella Titer			**Lab Report Required**

Name_____UNI _____

Additional requirements:

COVID-19 Vaccine/Booster: *Columbia University requires that all students must provide documentation of being **fully vaccinated** (defined as completion of the initial vaccination and booster dose, if eligible) by a COVID-19 vaccine that is authorized/approved by the US Food and Drug Administration or the World Health Organization.*

Vaccine *At least 14 days after receiving the second doseof you Pfizer or Moderna series (or other WHO- authorized vaccine), or at least 14 days after receiving a single dose of Janssen/Johnson & Johnson vaccine.* **Booster Eligibility** *In general, at least five months after the last doseof your initial Pfizer or Moderna series (or other WHO-authorized vaccine) or two months after theinitial J & J vaccination.*	**Vaccine/Booster**	**Date**	**Result**	**Copy Attached**
			N/A	**Copy of Vaccination Card Required**

Influenza: *Columbia University policy states that students receive or provide documentation they have received the seasonal influenza vaccine between August 1 of the Fall term and May 1 of the Spring term.*

Submit the date of your most recent vaccine	**Vaccine**	**Date**	**Result**	**Copy Attached**
			N/A	**N/A**

I attest that all dates, results, and immunizations listed on this form are correct and accurate.

Provider's Printed Name_____Date_____

Provider's Signature_____License Number_____

Clinician/Practice Stamp *(required)*

Physical Exam Form

This form must be completed by an MD/DO, NP, or PA who is not a relative. Only this form will be accepted as documentation of a physical exam.

This section to be completed by the student:

Last Name		**First Name**		**Middle Initial**	
UNI		**Date of Birth**		**School/Program**	
Full-time		**Part-time**		**Telephone Number**	

This section to be completed by a medical provider:

Visual Acuity: *(with correction, if any)* OD _____ OS _____ Correction? □ Yes □ No

Height *(inches)* _____ Weight *(pounds)* _____ BP _____ Pulse _____

	Normal	Abnormal	Not Done	If abnormal, please explain
General Appearance				
Head				
Eyes				
Ears, Nose, Throat				
Neck				
Lymph Nodes				
Breasts				
Heart				
Lungs				
Abdomen				
Pelvic Exam				
GU Exam				

Name _____ UNI _____

Rectal Exam				
Extremities				
Neurological Exam				

This student is in good health and is free of contagious disease. To the best of my knowledge, the student is free from any health impairment which is of potential risk to patients or which might interfere with the performance of assigned duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior. ☐ Yes ☐ No

Does this student require ongoing medical care? ☐ Yes ☐ No

Specify:

Provider's Printed Name _____ Exam Date_____

Provider's Signature _____ License Number_____

Clinician/Practice Stamp *(required)*