Weill Cornell Medicine

Visiting International Student Electives Health Form

Name: _____ Date of Birth: _____
Home institution: _____ AAMC ID: _____
Email: _____ Phone: _____

❑ **Section 1: Immunity to Measles, Mumps, Rubella, and Varicella** (must attach lab reports)

- Measles Titer (igG) Result Date: _____ Result: ❑ POS ❑ NEG
- Mumps Titer (IgG) Result Date: _____ Result: ❑ POS ❑ NEG
- Rubella Titer (IgG) Result Date: _____ Result: ❑ POS ❑ NEG
- Varicella Titer (IgG) Result Date: _____ Result: ❑ POS ❑ NEG

Vaccination Dates:
MMR #1 _____ MMR#2 _____ MMR#3 (if given) _____
Varicella #1 _____ Varicella #2 _____ Varicella #3 (if given) _____

❑ **Section 2: Immunity to Hepatitis B** (must attach lab reports)
Documentation of completed Hep B series AND post-immunization titer is required for all students.
Hep B #1 _____(date) Hep B #2 _____ (date) Hep B #3 _____(date)
Hepatitis B Surface Antibody (IgG) Result Date: _____ Result: ❑ POS ❑ NEG

Proceed to section 3 if Hep B immune. If Hepatitis B surface antibody testing does not show immunity:
Hepatitis B Surface Antigen Result Date: _____ Result: ❑ POS ❑ NEG
Additional Hep B doses (if initial post-immunization test AND hep B surface antigen are negative)
Hep B #4 _____(date) Hep B #5 _____ (date) Hep B #6 _____(date)
Repeat Hepatitis B Surface Antibody (IgG) Result Date: _____ Result: ❑ POS ❑ NEG

❑ **Section 3: Immunity to Tetanus and Pertussis**
Recent Td/Tdap (within 10 yrs) _____ Date of prior Tdap (post 2005) _____

❑ **Section 4: Tuberculosis Screening (Quantiferon Gold or T-spot)** (must attach lab report)
Quantiferon Gold: _____ (date must be within 12 months of elective) ❑ POS ❑ NEG

If Quantiferon Gold is POSITIVE only, clinician must complete the following:
Chest X-ray _____ (date must be within 12 months of elective) ❑ Normal ❑ Not normal
Did student complete INH or comparable treatment? ❑ Yes ❑ No _____
Is patient currently free of signs or symptoms of active tuberculosis disease? ❑ Yes ❑ No

❑ **Section 5: COVID Vaccination (required; attach proof of vaccination)**
Dose 1: Date: _____ Mfr: ❑ J&J ❑ Pfizer ❑ Moderna ❑ Other _____
Dose 2: Date: _____ Mfr: ❑ J&J ❑ Pfizer ❑ Moderna ❑ Other _____
Dose 3: Date: _____ Mfr: ❑ Pfizer ❑ Moderna ❑ Other _____

❑ **Section 6: Health Statement** (must be completed by evaluating/treating clinician)
Date of most recent physical examination: _____ (date must be within 12 months of start of elective)
By my signature below, I certify that this student is in good health and does not appear to have evidence of communicable illness or impairment that may pose a risk in the academic, clinical and laboratory settings with the following exceptions:
❑ None ❑ (specify on back of this document or attach add'l information from medical records).

Clinician Name and Title: _____ Office Address
Signature:_____ Date: _____ Stamp:

Weill Cornell Medicine

REQUIRED FOR PLACEMENTS FROM SEPTEMBER TO APRIL

Influenza Vaccine Documentation Form
(September through April Electives)

New York State law requires healthcare workers not immunized against influenza to wear a mask in all areas where patients may be contacted. Weill Cornell Medicine requires all students without medical contraindications to be immunized against influenza. Students participating in electives from September through May must provide documentation of receipt of flu vaccination.

Vaccination documentation on office letterhead/prescription or printout from an EMR is also acceptable as long as it contains the information requested below.

To be completed by **administering** healthcare practitioner:

By my signature I attest that the following individual has received the influenza vaccine for the influenza season:

Patient's name: _____ **Date of Birth** (mm/dd/yyyy): ____/_____/_____

Vaccine Name, Formulation and Dose: _____

Manufacturer: _____ Lot Number: _____ Exp. Date: _____

Date Administered (mm/dd/yyyy): _____

Name: _____

Title:_____

Signature: _____

Office Address: _____

_____

_____

Telephone Number: (_____)_____