

Welcome to The Culinary Institute of America
Hyde Park Campus!

Physical Examination & Health Information

In order to attend the CIA, it is a requirement to have a physical exam performed within the past year and obtain mandatory vaccinations. This information must be documented on the CIA forms. The completed CIA forms must be submitted no later than 45 days prior to your entry date.

The completed Physical Examination & Health Information packet must be submitted by mail, fax or e-mail. Failure to complete these requirements may result in an academic hold and a \$200 non-compliance fee.

The Culinary Institute of America
Student Health Services
1946 Campus Drive
Hyde Park, NY 12538

Fax#: 845-905-4061

E-mail: ciahealthservices@culinary.edu

Please e-mail or call the Student Health Office at 1-800-285-4627 ext. 1261 if you have any questions.

Entry Date: / /

Optional Student Recommendations:

- ❖ Covid vaccination
- ❖ Seasonal Influenza Vaccine
- ❖ Tetanus Vaccine

Mandatory Student Requirements :

- ❖ Tuberculosis (TB) screening questionnaire (page 2).
- ‡ Meningitis vaccination response form (page 5).

Mandatory Healthcare Provider Requirements:

- ❖ Two MMR vaccine dates or proof of immunity (page 1).
- ❖ Hepatitis A vaccine dates (page 1).
- ❖ Hepatitis B vaccine (if student <19 years old) (page 1).
- ❖ Health Care Provider Tuberculosis Risk Assessment, if warranted* (page 3).
- ❖ History and Physical Exam: signed and dated by a healthcare provider (page 4).

*See page 2 Tuberculosis (TB) Risk Assessment guidelines for reference.

The Culinary Institute of America
1946 Campus Drive, Hyde Park, NY 12538

Part I: Immunization Form

Student's Name: _____ Date of Birth: ____/____/____
(Last) (First) (MI)

Address: _____
(Street - Apt #) (City) (State - Zip)

NYS Public Health Law 2165 requires post-secondary students born 01/01/57 or later to show protection against measles, mumps, and rubella. Persons born prior to January 1957 are exempt from this requirement. The first dose of vaccine must be given on or after your first birthday.

Required Immunizations

Optional Immunizations

OPTION 1: MMR (Measles, Mumps, Rubella)

Signature or Official Stamp of Healthcare Provider

Guardian Signature (only if student <18 years of o

Name _____

Date of birth _____

Part IIb: Health Care Provider Tuberculosis Risk Assessment

Tuberculosis (TB) Risk Assessment – Provider H i

Healthcare Provider Signature

Name: _____

Date of birth _____

Part IIIa: Medical History

PAST MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Concussions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Seizure Disorder | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> Skin Disease | _____ |

Food Allergies: _____

Medication Allergies: _____

Additional Allergies: _____

Past Surgical History: _____

Daily Medications/Dosages: _____

Part IIIb: Mandatory Physical Exam

Height: _____ Weight: _____ BP: _____/_____ Pulse: _____

NORMAL

ABNORMAL

COMMENTS

	NORMAL	ABNORMAL	COMMENTS
Skin			
H.E.E.N.T.			
Neck/Thyroid			
Lymph Glands			
Lungs			
Cardiovascular			
Abdomen			
Back/Extremities			
Neurologic/Reflexes			
Hearing			
Vision			

Recommendations for Physical Activity: Unlimited Limited (please explain): _____

Healthcare Provider Signature: _____ Date of Exam: _____

Phone #: _____ Name (or stamp) _____

Address _____

Name: _____

Date of birth _____

Part V: Mandatory Meningitis Vaccination Response Form

New York State Public Health Law 2167 requires that colleges and universities distribute information about meningococcal disease and vaccinations to all students.

I have (check one box and sign below):

I had the meningococcal immunization within the past five (5) years. The date of vaccination was _____.

Note: The Advisory committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least one (1) dose of Meningococcal ACWY vaccine not more than five (5) years before ~~age 21 (or age 22, if a student)~~.
