A completed Health and Immunization record is one of the pre-registration requirements that you must submit before you are allowed to register and attend classes at Weill Cornell Medical College. You are encouraged to complete your records along with your current healthcare provider as soon as possible, to avoid any delay in registration and start of your coursework.

**IMPORTANT INSTRUCTIONS**

- This form must be completed by the matriculating student and his/her doctor. All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only.
- Please note that as a matter of institutional policy, all students **must demonstrate serologic immunity** to Measles Mumps, Rubella, Varicella and Hepatitis B.
- Laboratory reports must accompany all titers and antigens and must be in English.
- Chest x-ray reports and documentation of prior treatment must also be attached and in English. Screen captures from electronic medical records are not adequate documentation.
- In anticipation to submit the required serological titers (within 3 months of starting coursework) valid documentation of immunization will be accepted as presumptive evidence of immunity.
- **Please note: Non-compliance with any of the above will result in denial of your class registration and attendance.**
- If you have any questions and/or need any further assistance please contact Ms. ShyRose Baloch via email at shb2021@qatar-med.cornell.edu or by phone at + 974 4492-8519

**Consent for Access & Release of Student Medical Records**

I hereby submit my medical record to the Office of Student Affairs at Weill Cornell Medical College in Qatar. I understand that the purpose of requesting this medical and immunization history, and examination included in the medical record is to **a) determine my baseline medical status and fitness to pursue medical education at WCM-Q, and b) to comply with the immunization requirements of WCM-Q.**

I understand that this assessment and examination is not being performed for the purpose of diagnosing and treating any specific health problems I may have, and that this examination is not a substitute for regular assessment, examination and follow-up by my private health care provider. I understand further that WCM-Q will disclose to Hamad Medical Corporation (HMC) and other WCM-Q affiliates, as well as WCMC in New York and its affiliates, the results of my examinations and immunization history for the purposes stated above. No medical information will be released to anyone else without my written authorization, except in cases of medical emergency or as required by law, regulation or by order of a court or authorized governmental agency having jurisdiction.

I understand that my medical records will be kept in the Office of Students Affairs. Student Affairs will secure my records and keep them confidential. Only designated individuals will have access to them. I confirm that I have read and fully understand the above and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

Student Name: ___________________________________ Signature: ___________________________________

Date: ____________________________________________
Meningitis Information Response Form

Check one and sign below. Return this form with all other Health and Immunization Forms.

☐ I have had the meningococcal meningitis immunization within the past 10 years.

Date received: ______________ Type: ☐ Polysaccharide (Menomune) ☐ Conjugate (Meactra or Menveo)

Note: If you received the meningococcal vaccine available before February 2005 called Menomune, please note this vaccine’s protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine, called Menactra, should be considered within 3-5 years after receiving Menomune.

☐ I have read, or have had explained to me the information regarding the meningococcal meningitis disease. I understand the risk of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal disease. I may change my mind at any time prior to vaccination and will execute a new response form accordingly.

Printed Name _______________________ Date of Birth _______________________
Signature _________________________ Date Signed _________________________
Part 1: Personal Medical and Mental Health History

Student Name (Last, First, Middle): _____________________________________________ Date of Birth: _______________

Do you have any ongoing health problems or conditions requiring medical care? □ Yes □ No
   If yes, please indicate: ______________________________________________________

Do you take any regular medications, vitamins or supplements? □ Yes □ No
   If yes, please list: __________________________________________________________

Do you have any allergies to medication? □ Yes □ No
   If yes, please list: __________________________________________________________

Do you have any allergies to latex or other non-medications? □ Yes □ No
   If yes, please list: __________________________________________________________

Have you had any surgeries or have been hospitalized or any reason? □ Yes □ No
   If yes, please indicate what surgery and the year it occurred: ______________________

Have you had? Have you had? Have you had? Have you had? Have you had?
<table>
<thead>
<tr>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung disease/Asthma</td>
<td></td>
<td></td>
<td>Anemia or other blood disorder</td>
<td></td>
<td></td>
<td>Serious disease of eye, ears, nose, or throat</td>
<td></td>
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<tr>
<td>Heart problems</td>
<td></td>
<td></td>
<td>Bone, joint, or muscle problems</td>
<td></td>
<td></td>
<td>Headache/Migraines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High or low blood pressure</td>
<td></td>
<td></td>
<td>Physical deformity or paralysis</td>
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<td></td>
<td>Cancer or other tumor</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Stomach trouble</td>
<td></td>
<td></td>
<td>Worry or nervousness</td>
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<tr>
<td>Liver disease /Hepatitis</td>
<td></td>
<td></td>
<td>Eating disorders</td>
<td></td>
<td></td>
<td>Recent gain or loss of weight</td>
<td></td>
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<tr>
<td>Kidney disease</td>
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<td></td>
<td>Malaria</td>
<td></td>
<td></td>
<td>Thyroid/other endocrine disorder</td>
<td></td>
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<tr>
<td>Recurrent diarrhea</td>
<td></td>
<td></td>
<td>Dizziness, fainting</td>
<td></td>
<td></td>
<td>Trouble sleeping</td>
<td></td>
<td></td>
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<tr>
<td>Learning disability</td>
<td></td>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part 2: Personal Medical & Mental Health History (continued)

Have you have any Tropical Diseases? □ Yes □ No
   If yes, please specify: _____________________________________________________

Have you received treatment or counseling for a nervous condition, personality or character disorder or emotion problem?
□ Yes □ No If yes, please specify: _____________________________________________

Please check if any of these apply:
Alcohol use: □ No □ Yes If yes, specify: drinks/week __________________________________
Tobacco use: □ No □ Yes If yes, specify: type and amount/week _________________________
Other drug use: □ No □ Yes If yes, specify: substance and frequency ____________________
# Part 3: Physical Examination Form

Name: (Last, First, Middle) ________________________________________________________________

Date of Birth (mm/dd/yyyy): / / 

WCMC-Q Program:  □ Foundation  □ Pre-Medical  □ Medical

**Physical Exam** (date of exam must be within one year of school enrollment date - mm/dd/yyyy): _ / __ / _

Visual acuity (with correction if any) 00 / OS / OU / Col Vision Pass/Fail Correction? □ No  □ Yes

Height:    Weight:    BMI:    BP:    Pulse:

<table>
<thead>
<tr>
<th>General Appearance</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Done</th>
<th>If abnormal, comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General appearance</td>
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</tr>
<tr>
<td>Head</td>
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<tr>
<td>Ears, Nose, Throat</td>
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<td>Hearing</td>
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<td>Neck</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Thyroid/ Carotid pulses</td>
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</tr>
<tr>
<td>Heart</td>
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<tr>
<td>Lungs/ Chest</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Examination / Joints</td>
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<tr>
<td>Spine/ Back/ ROM</td>
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<tr>
<td>Extremities</td>
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</tr>
<tr>
<td>Neurological Exam</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Does this student require ongoing medical care for any health problems? □ No  □ Yes

If yes, please specify and attach any available documentation: ____________________________________________________________

Final clinical impression: _______________________________________________________________________________________

Clinician Name: ___________________________  Date: ___________________________

Clinician Signature & Stamp ___________________________  Office Telephone: ___________________________

Student Name (Last, First, Middle): ___________________________  Date of Birth: _________________
Part 4: Student Immunization Form
(To be completed by a licensed physician, nurse practitioner, physician assistant or registered nurse)

REQUIRED BY ALL STUDENTS:
For students unable to obtain titers, clinician should document vaccination dates and arrangements to have titers drawn when student arrives on campus should be done immediately.

Record all dates in MM/DD/YYYY format and ATTACH ALL LAB AND CHEST X-RAY REPORTS.

Name: (Last, First, Middle) ____________________________________________________________

Date of Birth (mm/dd/yyyy): _ / _ /

Measles Titer (IgG)  Date: __________  □ Immune  □ Non-Immune
Mumps Titer (IgG)  Date: __________  □ Immune  □ Non-Immune
Rubella Titer (IgG)  Date: __________  □ Immune  □ Non-Immune

If unable to obtain titers, record dates of vaccine. If titers are negative or equivocal, record dates of booster.

MMR #1 __________  MMR #2 __________  OR
Measles #1 __________  Mumps __________  Rubella __________
Measles #2 __________

Hepatitis B Surface Antibody Titer  Date: __________  □ Immune  □ Non-Immune

If antibody titer is non-immune, record dates of vaccine series.

Dose #1 __________  Dose #2 __________  Dose #3 __________

Varicella Titer (IgG)  Date: __________  □ Immune  □ Non-Immune

If antibody titer is non-immune, record dates of vaccine (2 doses). If titers are negative or equivocal, record dates of booster.

Dose #1 __________  Dose #2 __________

Tetanus/ Diphtheria (within 10 years)  Date: __________  Type: □ Td  □ Tdap
Meningococcal (within 3 years)  Date: __________  Type: □ Polysaccharide (Menomune)  □ Conjugate (Menactra or Menveo)
Polio (most recent)  Date: __________  Type: □ OPV  □ IPV

Note to clinician: Tine test and Quantiferon Gold are not accepted. TST must be performed within the last 90 days regardless of history of BCG vaccination, unless there is a prior history of a positive TST. Chest x-rays must be dated AFTER a positive TST result.

Date Placed: __________  Date Read 48-72 Hours Later: __________  Results: __________ mm of induration

If Negative CXR and Positive PPD, did you complete a course of INH? □ No  □ Yes
If yes, how many months did you take INH ______ (# of months) and dates of treatment __________
Free from signs or symptoms of active tuberculosis disease? □ No  □ Yes
BCG History □ No  □ Yes

Clinician Name: __________________________________________  Date: __________
Clinician Signature & Stamp __________________________________ Office Telephone: ________________________