Weill Cornell Medicine-Qatar

Please return this form to:
Office of the Registrar --Student Affairs Division
Weill Cornell Medicine Qatar
C/O Ms. ShyRose Baloch
P.O. Box 24144
Doha, Qatar

WCM-Q Health and Immunization Form

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: _____

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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 _____

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

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 20/ OS 20/ OU 20/ Col Vision Pass/Fail Correction? ☐ No ☐ Yes

Height: Weight: BMI: BP: Pulse:

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

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

PPD (Mantoux)

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: _____