Welcome to The Culinary Institute of America
San Antonio 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).

Mandatory Healthcare Provider Requirements:

- ☐ Meningococcal vaccination/Booster if **< 22 years of age** (page 1)
- ☐ Hepatitis A vaccine dates (page 1).
- ☐ Two MMR vaccine dates **or** proof of immunity (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)

Required Immunizations

Meningitis vaccine (mandatory if student is < 22 years of age) given within the past 5 years

Meningitis #1__/__/___ ____

Meningitis #2_____/_____/_____

Hepatitis A vaccine (minimum 6 months apart)

Hep A #1____/____/___

Hep A #2____/____/___

OPTION 1: MMR (Measles, Mumps, Rubella

MMR #1_____/_____/_____

MMR #2 _____/_____/_____

OPTION 2: Antibody Titers (attach lab reports)

Measles titer date / /___ ❑ Lab report attached

Mumps titer date / /___ ❑ Lab report attached

Rubella titer date____/ / ❑ Lab report attached

Optional Immunizations

Hepatitis B vaccine

Hep B #1____/_____/_____

Hep B #2 ____/_____/_____

Hep B #3_____/_____/_____

Varicella vaccine

Varicella #1_____/_____/_____

Varicella #2_____/_____/_____

❑ Disease

Tetanus Diphtheria Pertussis

(most recent vaccine/booster)

Td_____ or Tdap_____

Seasonal Flu vaccine _____/_____/_____

☐ Waiver Submitted

COVID vaccine – Please submit after fully vaccinated

COVID #1____/____/____ ❑ Vaccine Card Attached

COVID #2 ____/____/____ ❑ Vaccine Card Attached

BOOSTER ____/____/____ ☐ Vaccine Card Attached

_____ _____

Signature *or* Official Stamp of Healthcare Provider Date

Name_____ Date of birth_____

Part IIa: Mandatory Tuberculosis Risk Assessment

Tuberculosis (TB) Risk Assessment – Student Questions

1. Have you ever had close contact with anyone who was sick with tuberculosis (TB)? ❑ Yes ❑ No
2. Have you ever had a positive TB skin test? ❑ Yes ❑ No
3. Have you been an employee, volunteer, or resident in a high-risk setting (e.g. correctional facility, healthcare facility, homeless shelter)? ❑ Yes ❑ No
4. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please **CIRCLE** the country). ❑ Yes ❑ No
5. Have you ever had frequent or prolonged visits (>1 month) to one or more of the countries listed below? (If yes, **CIRCLE** the country below). ❑ Yes ❑ No

Afghanistan	Congo	Iran (Islamic Republic of)	Singapore	Namibia
Algeria	Côte d'Ivoire	Iraq	Solomon Islands	Nauru
Angola	Democratic People's Republic of Korea	Kazakhstan	Somalia	Nepal
Anguilla	Democratic Republic of the Congo	Kenya	South Africa	Nicaragua
Argentina	Djibouti	Kiribati	South Sudan	Niger
Armenia	Dominican Republic	Kuwait	Sri Lanka	Nigeria
Azerbaijan	Ecuador	Kyrgyzstan	Sudan	Niue
Bahamas	El Salvador	Lao People's Democratic Republic	Suriname	Northern Mariana Islands
Bangladesh	Equatorial Guinea	Latvia	Swaziland	Pakistan
Belarus	Eritrea	Lesotho	Syrian Arab Republic	Palau
Belize	Ethiopia	Liberia	Tajikistan	Panama
Benin	Fiji	Libya	Thailand	Papua New Guinea
Bhutan	French Polynesia	Lithuania	Timor-Leste	Paraguay
Bolivia (Plurinational State of)	Gabon	Madagascar	Togo	Peru
Bosnia and Herzegovina	Gambia	Malawi	Trinidad and Tobago	Philippines
Botswana	Georgia	Malaysia	Tunisia	Poland
Brazil	Ghana	Maldives	Turkey	Portugal
Brunei Darussalam	Greenland	Mali	Turkmenistan	Qatar
Bulgaria	Guam	Marshall Islands	Tuvalu	Republic of Korea
Burkina Faso	Guatemala	Mauritania	Uganda	Republic of Moldova
Burundi	Guinea	Mauritius	Ukraine	Romania
Cambodia	Guinea-Bissau	Mexico	United Republic of Tanzania	Russian Federation
Cameroon	Guyana	Micronesia (Federated States of)	Uruguay	Rwanda
Cape Verde	Haiti	Mongolia	Uzbekistan	Sao Tome and Principe
Central African Republic	Honduras	Morocco	Vanuatu	Senegal
Chad	India	Mozambique	Venezuela (Bolivarian Republic of)	Serbia
China	Indonesia	Myanmar	Viet Nam	Sierra Leone
China, Hong Kong SAR			Yemen	
China, Macao SAR			Zambia	
Colombia			Zimbabwe	
Comoros				

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2016. Countries with incidence rates of ≥ 20 cases per 100,000 population

If the answer to all the above questions is **NO**, no further testing or further action is required.

If the answer is **YES** to any of the above questions, the CIA requires that a **healthcare provider** complete a Tuberculosis Risk Assessment (Part IIb, page 3).

Student Signature:_____ **Date:**_____

Guardian Signature (if student <18 years of age):_____ **Date:**_____

Name_____ Date of birth_____

Part IIb: Health Care Provider Tuberculosis Risk Assessment

Tuberculosis (TB) Risk Assessment – Provider Questions

1. Has the student ever had a **positive** TB skin test or TB blood test? ❑ Yes ❑ No
2. Does the student have a medical condition associated with increased risk of progressing to TB disease if infected (e.g.HIV infection; head/neck/lung cancer; hematologic disease such as leukemia or Hodgkin's disease; end stage renal disease; chronic malabsorption)? ❑ Yes ❑ No .
3. Is the student a member of a high-risk group? ❑ Yes ❑ No

If all the answers above are **NO**, student is considered low risk and no further testing is needed.
If any of the answers above are **YES**, student is considered high risk and requires further TB screening.

TUBERCULOSIS SCREENING (within past 6 months):

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease? **(Check all that apply).**

❑ Cough (>3 weeks)
❑ Coughing up blood (hemoptysis)
❑ Chest pain
❑ Loss of appetite
❑ Unexplained weight loss
❑ Night sweats
❑ Fever (> 1 week)

If **no** symptoms are checked, proceed to TB skin/blood test.
If **any**, symptoms are checked, provide documentation of evaluation to exclude active tuberculosis disease (TB testing, chest x-ray, sputum evaluation, as indicated).

TB Skin Test (results must be read in 48-72 hours): Date Placed_____ Date Read _____ **Results**_____mm induration **Interpretation** ❑ positive ❑ negative	**Quantiferon Test or T-Spot Test** (a copy of the lab report **must** be provided): Date obtained_____ **Results** _____

CHEST X-RAY (REQUIRED IF SKIN OR BLOODTEST IS POSITIVE):

Date _____ Result (attach copy of report): ❑ normal ❑ abnormal

Treatment/recommendations:

_____
_____

_____ _____
Healthcare Provider Signature **Date**

San Antonio – Revised 2/14/2023

Name:_____ Date of birth_____

Part IIIa: Medical History

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

❑ ADD/ADHD	❑ Concussions	❑ Heart Disease	❑ Substance Abuse
❑ Anxiety	❑ Depression	❑ High Blood Pressure	❑ Thyroid Disease
❑ Asthma	❑ Diabetes	❑ Kidney Disease	❑ Tobacco Use
❑ Bipolar Disorder	❑ Digestive Problems	❑ Seasonal Allergies	❑ Other _____
❑ Bleeding Disorder	❑ Eating Disorder	❑ Seizure Disorder	_____
❑ Cancer	❑ Fainting	❑ 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
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:_____

Name (or stamp)_____Phone #_____

Address_____Fax #_____