Weill Cornell Medicine-Qatar

***Please return this form to:***
*Office of the Registrar -Student Affairs Division*
*Weill Cornell Medicine - Qatar*
**C/O Ms. Jyothi Rosario**
*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 Medicine - Qatar. 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. Jyothi Rosario** via email at **jyr2001@qatar-med.cornell.edu.**

## Consent for Access & Release of Student Medical Records

I hereby submit my medical record to the Office of Student Affairs at Weill Cornell Medicine - 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: _____

WCM-Q ID: _____

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 (Menactra or Menveo)

Note: If you received the meningococcal vaccine available before February 2015 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, however, I have decided that I will not obtain immunization against meningococcal disease.

Printed Name: _____ Signature: _____

Date of Birth: _____ Date Signed: _____

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# COVID-19 Vaccination Form

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

□ I have completed the Covid-19 Vaccination in Qatar / Other location: _____

**1st Dose received**: _____ **2nd Dose received**: _____ **Booster Dose received**: _____

**Type of Vaccine**: _____

□ I understand the health implications after contracting or exposure to Covid-19 positive people or patients. I also understand that my attendance at classes and clinics will be impacted by not receiving any vaccination. In addition, I may only be able to continue with the registered courses once vaccinated.

Printed Name: _____ Signature: _____

Date of Birth: _____ 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 for 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 | | | Thyroid / other endocrine disorder | | | Learning disability | | |
| Heart problems | | | Physical deformity or paralysis | | | Eating disorders | | |
| Kidney Disease | | | Anemia or other blood disorder | | | Dizziness, Fainting | | |
| Liver Disease / Hepatitis | | | Bone or Joint problems | | | Cancer or other tumor | | |
| Stomach trouble | | | Muscle problems | | | Recent gain or loss of weight | | |
| Disease of eyes, ears, nose, or throat | | | Headaches & Migraines | | | Trouble sleeping / Insomnia | | |
| Anxiety | | | Diabetes | | | Seizures / Convulsions | | |
| Depression | | | High Blood Pressure | | | Epilepsy | | |

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

Have you had or suffered from 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/ OD 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

Covid-19 Vaccine 1st Dose: _____ Type: _____ Country of Vaccination: _____
2nd Dose: _____
3rd Dose: _____

TB Screening The only TB test accepted by WCM-Q from January 2023 is the Quantiferon Gold test.
Note: If the result is positive, you are required to get a Chest X-Ray as well.

Test Date: _____ Result: _____

Clinician Name: _____ Date: _____

Clinician Signature & Stamp: _____ Office Telephone: _____