SCHOOL OF OSTEOPATHIC MEDICINE

December 11, 2019

Dear Accepted Student,

On behalf of the Department of Family Medicine, I would like to congratulate you on your acceptance to Rowan University School of Osteopathic Medicine, (RowanSOM), and welcome you to the osteopathic family! The Department of Family Medicine is responsible. To ensure that all entering students have met the student health requirements necessary to matriculate at RowanSOM.

Enclosed please find a copy of the RowanSOM incoming student health packet. The health packet includes:

1. A medical history questionnaire
2. A physical examination form
3. RowanSOM required immunization/testing form and check list

These documents must be completed and returned to me within 8 weeks of receipt of this letter. Please read each document carefully and complete as directed. The physical examination, testing and any needed vaccination(s) are to be completed by your personal physician. Please ensure that you have the proper documentation needed for your physician to complete your immunization record. DO NOT assume that your paperwork has been received, you will be contacted by Ms. Charise Emery once she receives your packet. It is **your responsibility** to follow up. **You risk losing you seat in our class if all of the materials are not received within 8 weeks of receipt of this letter.**

Please note that information contained within your Student Health Records may be disclosed to other persons or offices if considered necessary by our office for the health or safety of any individual(s) or to determine a student's ability to fulfill the Essential Functions of your educational program. Your health information is protected under HIPAA.

Any disclosure made to the Student Health Office on the medical history questionnaire or physical examination form, or in any other manner does not constitute notice to RowanSOM of a disability or handicap and will not be considered a request for accommodations. All requests for reasonable accommodations must be made directly to RowanSOM in accordance with the procedures of our school. Questions regarding accommodations may be referred to Jacqueline Giacobbe, M.S.Ed., in The Center for Teaching and Learning, (856-566-6738).

All students will be required to maintain health insurance while at RowanSOM. You will be directly charged comparable health insurance coverage. The School's insurance will be effective after matriculation (and therefore may not be used to complete any requirements for matriculation). More information about the School's health insurance program and the waiver process will be sent to you in a future mailing.

I want you to know also that RowanSOM is a smoke/tobacco free campus, this includes e-cigarettes. No use of tobacco products is allowed on campus, which includes all parking lots and undeveloped areas. There is a free smoking cessation program you have the option to access.

Again, welcome to RowanSOM! If you have any questions about student health, please do not hesitate to contact Ms. Charise Emery, CMA at RowanSOM, Department of Family Medicine, Student Health/Employee, University Doctor's Pavilion, 42 E. Laurel Road, Suite 2500, Stratford, NJ 08084, (856-566-6825).

I look forward to meeting each of you this year.

Sincerely,

Todd Schachter, D.O., F.A.O.C. Pr.
Director of Student Health/Employee Health

STUDENT HEALTH CHECKLIST

These requirements can take substantial time to complete, so please obtain immediately so your packet will be completed ON TIME. Use the below checklist to help ensure you have a complete packet.

- **Tdap** (Tetanus/diphtheria/pertussis). *All students must have prior to matriculation, received one dose of **Tdap**, since their primary series, regardless of when the last tetanus booster was given. **Tdap** within the last five years is required.*

- **Rubeola IgG titer** showing immunity

- **Mumps IgG titer** showing immunity

- **Rubella IgG titer** showing immunity
- 3 doses of Hepatitis B vaccine, AND a QUANTATIVE Hepatitis B surface Antibody titer showing immunity. (*Results listed as reactive or positive are **NOT** acceptable*).

- Hepatitis B Core Antibody, total and Hepatitis B Surface Antigen screen and Hepatitis B Surface Antibody, quantitative are required. This is to determine past/current infectivity.

- Varicella IgG titer showing immunity, within 5 years

- 2-STEP PPD, which is 2 separate PPD tests, done 1-3 weeks apart, the last one **MUST** be after April 1, 2020. Results **must** include date given, date read and the induration in mm (not positive or negative readings). This requirement is **regardless** of a previous BCG. Students with a previously positive PPD must submit a current chest x-ray report (within the last 12 months). If you have had a previous PPD after 8/2019, you may submit all documentation for that PPD **PLUS** a recent PPD after 1/1/2020 instead of a 2-STEP PPD. A **Quantiferon TB gold** (not a T-spot) done within 6 months is an acceptable substitute. Please include the laboratory report.

- A completed History and Physical. MUST BE DATED, SIGNED AND STAMPED BY THE STUDENT'S PRIMARY CARE PROVIDER, DONE WITHIN 6 MONTHS, **ON OUR FORMS**.

REMINDER: the above requirements need to be received, correct and completed, within 8 weeks of receipt of this letter to ensure your matriculation in July 2020. **Failure to comply may jeopardize your matriculation**.

(The above requirements are standard for most medical schools so there is no reason to wait on which school you decide on).

Rowan University
SCHOOL OF OSTEOPATHIC MEDICINE

TIPS ON TURNING IN YOUR HEALTH PACKET CORRECTLY

1. Hepatitis B surface antibody Titer…**CANNOT** just be a reactive result, we need the titer to verify immunity by a level. This test needs to be done as a QUANTITATIVE result not a QUALATATIVE result. Those who are not immune WILL BE required to receive one vaccine and repeat blood work will be due one month later to check immunity. If the result after the booster proves immunity, there isn't anything else that needs to be done. If the result is negative, then you are required to finish out the last two vaccines and repeat blood work for Hepatitis B surface antibody QUANTATATIVE one month after the third vaccine. It will be **YOUR** responsibility to remember your upcoming requirements and turn them into the Student Health Office. Failure to do so will result in a GSBS/PHD student receiving a hold on their account and a Medical Student will be given disciplinary action!!

   Test codes for the two most commonly used labs are below.

   QUEST
   Hepatitis B surface antibody quantitative: #8475
   Hepatitis B core antibody total: #501
   Hepatitis B surface antigen: #498

   LAB CORP
   Hepatitis B surface antibody quantitative: #006530
   Hepatitis B core antibody total: #006718
   Hepatitis B surface antigen: #006510

2. Hepatitis B core antibody needs to be ordered as a **TOTAL**, not IGM/IGG.
3. Tetanus booster needs to be a Tdap (adacel). TD is **NOT** acceptable.
4. PPD needs to be read in mm, not listed only as a negative result.
5. A two-step PPD is **required**. If you had a PPD within a year, you may use that as your first one, then all you will need is a second PPD. If you have **NOT** had a PPD within a year, you will need two. Your PPD can be done 1-3 weeks apart. You can substitute the PPD's by doing a quantiferon tb gold blood draw. This needs to be done within the past 6 months. The T-spot test is **NOT** acceptable.
6. Prior BCG does **NOT** exclude doing the PPD test unless you have tested positive before, then you will need to submit a chest X-ray OR a quantiferon TB gold test.
7. Immunity is required for MMR and Varicella. If any of these tests come back showing you are **NOT** immune, you will be **required** to receive a booster and repeat blood work will be due one month after your booster.
8. A script to get upcoming blood word is to be provided by your PCP.
9. Copies of all laboratory tests are **required**.

ROWAN UNIVERSITY SCHOOL OF OSTEOPATHIC MEDICINE
STUDENT HEALTH FORM

IMPORTANT------STUDENT HEALTH REQUIREMENTS----- IMPORTANT

Rowan University-School of Osteopathic Medicine, (RowanSOM) requires that all students enrolling in any school or program, including programs sponsored jointly by RowanSOM and another institution, must comply with its policy on sh1dent health and immunizations prior to enrollment and/or first matriculation. Please complete the following form and return it to the **Director of Student Health Services**, University Doctors Pavilion, 42 E. Laurel Road, Suite 2500, Stratford, NT 08084. In addition, you should make a copy of the form and bring it with you when you register. If you have any questions, call the Director of Student Health Services at (856) 566-6825 or fax to (856) 566-6899.

Enrollment Date (month/year):_______________________________Class Year:___________________

Name: ____
(Last) (First) (Middle)

Address:____
(Street)

____
(City) (State) (Zip)

Telephone: (_____)_______-__________________Social Security #: __________________________

Birthday: ______________________ Sex: ( ) Male ( ) Female
(Month/Day/Year)

SECTION A – REQUIRED IMMUNIZATIONS

(Please provide a copy of your immunization record if given by professional other than certifying physician below).

1. Measles-Mumps-Rubella:
   All students must submit documented proof of immunity to measles, mumps and rubella (German Measles) prior to matriculation or enrollment. Students lacking documentation of immunity must receive 1 does of MMR before enrollment and a 2nd dose taken no less than one month later. Immunity can be proven by:

   Serologic (laboratory) evidence of immunity to each disease, (attach a copy of results)

   MMR: Dates of Immunization: #1_____________________#2_________________________

   Measles: Dates of Immunization: #1___________#2__________Date of Positive Serum Titre:__________

   German Measles (Rubella): Date of Immunization: __________Date of Positive Serum Titre:__________

   Mumps: Date of Immunization: __________________________Date of Positive Serum Titre:__________

SECTION A – REQUIRED IMMUNIZATIONS (*cont.*)

2. Tetanus-Diphtheria-Acellular Pertussis (TDAP): All students should have completed a primary series of diphtheria, pertussis and tetanus immunizations (DPT), and received a booster dose of Tdap (tetanus-diphtheria-pertussis) within the last 5 years. Students must have the Tdap prior to matriculation or enrollment.

   a. Dates of Primary Series: #1__________#2__________#3__________#4___________

   b. Date of Last Booster: ___________TDAP Booster__________(Td booster NOT acceptable)

3. Hepatitis B – Immunization: All students must be vaccinated against Hepatitis B (3 doses of vaccine) prior to or within 9 months of initial enrollment, and be able to demonstrate serologic (laboratory) evidence of immunity to hepatitis B.

   a. Date(s) of Immunization: #1_____________#2______________#3_______________

4. Varicella (*Chicken Pox*): All students must, prior to matriculation or enrollment, submit documented proof of immunity to varicella as proven by serologic (laboratory) evidence of immunity to varicella-zoster virus (attached a copy of results)

   a. Dates of Immunization: #1________________________#2______________________

5. Influenza: All students must be immunized annually in the Fall with the current influenza vaccine.

   a. Date of last vaccination: _____________________

SECTION B – RECOMMENDED IMMUNIZATIONS, BUT NOT MANDATORY

Polio: All students should have completed a full 3-dose primary series of poliovirus vaccine. Students who have not completed or cannot document a primary series of poliovirus vaccine should receive at least one additional dose or a full 3-dose series, as appropriate, of enhanced-potency inactivated polio vaccine.

Date(s) of Primary Series:____

a. Date of Last Booster:____

Type of Vaccine:_________Live (OPV)________Inactivated (IVP)_________Enhanced Potency (EP-IPV)

SECTION C – REQUIRED LABORATORY TESTING

ALL students MUST have the following lab tests regardless of past immunization:
A copy of these blood tests must be attached. They must be within the last 5 years.

(a) Hepatitis B surface antigen
(b) Hepatitis B surface antibody QUANTITATIVE, (titer for immunity is the ONLY acceptable test)
(c) Hepatitis B core antibody, TOTAL (is the only acceptable test)
(d) Rubella IgG (German measles) titer for immunity

(e) Mumps IgG titer for immunity
(f) Rubeola IgG (measles) titer for immunity
(g) Varicella IgG titer for immunity (h) Quantiferon TB Gold (optional)

SECTION D – REQUIRED TUBERCULOSIS TESTING

A PPD test (Mantoux) within 3 months of matriculation in July is required, a second Mantoux test within 1-3 weeks of first (**TWO-STEP**) must be performed if there is no documented negative Mantoux within the prior 12-months. A Mantoux test should be performed regardless of prior Bacille Guerin (BCG) vaccinations. Students with a history of a positive PPD test **should not** be retested. Those individuals should be considered "previously infected" and cared for accordingly (i.e. chest x-ray examination must be within the last 12 months). Mantoux test must be read in **mm**, not just pos. or neg**. with the date placed and the date read**. A Quantiferon TB Gold (not a T-spot) done within 6 months is an acceptable alternative.

(a) Date of PPD Test: #1______________________ Date Test read: _________________
PPD Test Results: _____________ mm. induration///________Negative __________Positive

(b) Date of PPD Test: #2______________________ Date Test read: _________________
PPD Test Results: _____________ mm. induration///________Negative __________Positive

(c) Date of Positive PPD Test: ______________________ D
Date of most recent chest x –ray: _________________ Result: ________________________
Was medication given for positive PPD Test? ______ (YES) _______(NO)
List medication(s) and dates used: ____

(d) Quantiferon TB gold ____(attach report)

SECTION E – MEDICAL HISTORY AND PHYSICAL EXAMINATION

All students shall undergo a complete history and physical examination within six months prior to first matriculation or enrollment and at annual or other appropriate intervals thereafter if indicated by the initial findings. Copies of these forms are attached. Please have a licenses physician complete and return the forms to the Director of Student Health, Rowan Medicine, 42 Laurel Road, Suite 2500, NJ 08084. In addition, make a copy of each form and bring it with you when you register.

(a) Date of Medical History: _______________(b) Date of Physical Examination: _____________

SECTION E – CERTIFICATION

I certify the above information is correct:

Physician's Name (PLEASE PRINT): ____

Physician's Signature: ___________________________________Date: ___________________________

Physician's Address or Stamp: ____
(Street Address)

____
(City) (State) (Zip)

Telephone Number: (_____) __________________E-mail Address: _______________________________

ROWAN UNIVERSITY SCHOOL OF OSTEOPATHIC MEDICINE
STUDENT HEALTH FORM- PERSONAL HEALTH HISTORY

Student's Name: ____ Age: ________ Date: _____________

1. Please list any medication you are taking, prescription and over-the-counter: ____________________

____

2. Please list any hospitalization and/or surgeries you may have had: ____________________________

____

3. Please list any allergies you may have: ____

4. Please provide the following social information. Do you use:

Alcohol _____ (NO) _______ (YES) How much: ____________________________

Tobacco _____ (NO) _______ (YES) How much: ____________________________

Caffeine _____ (NO) _______ (YES) How much: ____________________________

Recreational Drugs _____ (NO) _______ (YES) What and how often: ____________________

Do you have children? __ (NO) _______ (YES) Please give ages: ______________________

Have any dependents, adults or children, living in your home? _____ (NO) ______ (YES), please give

relationship(s) and age(s): ____

____

Please provide your marital status: (Please circle) Single/Married/Divorced/Widowed/Separated

Are you employed?____ (NO) ______ (YES) Please give occupation: ________________________

Have you any pets living in your home? ______ (NO) _____ (YES)

Is there a firearm in your home? ______(NO) _____ (YES) Is it unloaded and locked: ___

5. Please provide the following Family History. Has any family member had the following:

	NO	YES	RELATION		NO	YES	RELATION
Alcohol/Drug Dependence	____	_____	___________	Mental Illness	____	____	___________
Allergy/Asthma	____	_____	___________	Rheumatic Fever	____	____	___________
Cancer	____	_____	___________	Sickle Cell	_____	____	___________
Convulsive Disorder	____	_____	___________	Stroke	_____	____	___________
Diabetes	____	_____	___________	Tuberculosis	_____	____	___________
Heart Disease	____	_____	___________	Kidney Disease	_____	____	___________
High Blood Pressure	____	_____	___________	Other	_____	____	___________

	Alive	Deceased	Health Concerns
Mother	__________	____________	____
Father	__________	____________	____
Sibling	__________	____________	____
Sibling	__________	____________	____
Sibling	__________	____________	____
Sibling	__________	____________	____

6. Please describe your dietary habits: ____

____

____

7. Please provide the following personal health history. Please check if you have ever been treated for:

___AIDS/HIV	___Emphysema	___Pneumonia
___Alcohol/Drug Dependence	___Gall Bladder Diseases	___Rheumatic Fever
___Allergies/Hayfever	___Glaucoma	___Seizure
___Asthma	___Headache/Migraine	___STD
___Anemia	___Heart Attack	___Stroke/mini-stroke
___Arthritis/Gout	___Heart Disease	___Thyroid disease
___Bladder Infection	___Hemorrhoid	___Tuberculosis
___Bleeding Disorder	___Hepatitis/Jaundice	___Ulcer
___Blood clot	___High Blood Pressure	___OTHER_______________
___Blurred Vision	___Infections (Type)	___________________________
___Broken Bone	___Irregular Heart Beat	___________________________
___Bronchitis	___Irritable Bowel	___________________________
___Cancer	___Kidney Disease	___________________________
___Colitis	___Kidney Stone	___________________________
___Diabetes	___Mental Illness	___________________________

Do you have now, or have you had any of the following in the past 2 weeks:

___Blood in Stool	___Joint Pain
___Blood in Urine	___Leg Pain When Walking
___Blurry Vision	___Muscle Weakness
___Change in Bowel Habit	___Nausea/Vomiting
___Change in Mole; (size, color, etc.)	___Night Sweats
___Chest Pain	___Nose Bleeds
___Chronic Fatigue	___Numbness/Tingling in Extremities
___Constipation	___Painful Urination
___Cough	___Palpitation
___Decreased Hearing	___Ringing in the Ears
___Diarrhea	___Shortness of Breath with Exertion
___Difficulty Urinating	___Shortness of Breath at Rest
___Dizziness/Lightheadedness	___Skin Diseases
___Excessive Thirst	___Skin Diseases
___Fainting Spell	___Swollen Extremity
___Frequent Urination	___Tremor
___Heartburn/Indigestion	___Weight Gain
___Heart Murmur	___Weight Loss
___Intolerance to Cold	___OTHER:___________________________________
___Intolerance to Heat	____

WOMEN	**MEN**		
Age of menopause: ______________________	Difficulty urinating?	____ NO	___YES
Age of start menstruation: _________________	Discharge from penis?	____NO	___ YES
Last Mammogram: (date): _________________	Hernia?	_____NO	___ YES
Last Menstrual Period; (date): ______________	Loss of sexual drive?	_____NO	___ YES
*Usual length of cycle: ______________	Lump in testicle?	_____ NO	___ YES
Last Pap Exam; (date): ____________________	Prostate problem?	_____ NO	___ YES

Loss of sexual drive? __________NO______YES
Lump in breast? __________NO______YES
Vaginal discharge? __________NO______YES

Number of pregnancies, if any: ______________________

Please inform us of any other information that would be helpful to us meeting your healthcare needs:

____

____

ROWAN UNIVERSITY SCHOOL OF OSTEOPATHIC MEDICINE
STUDENT HEALTH FORM- INITIAL PHYSICAL

Student's Name: ____Age: ________ Date: _____________

Ongoing/Current Medical Problems: ____

____

____

Weight: ___________ Height: ___________ Temperature: ________ Blood Pressure: ____________

General Appearance: ____

____

Skin: ____

____

Head: ____

____

Eyes: ____

____

Ears: ____

____

Nose: ____

____

Mouth/Throat: ____

____

Neck: ____

____

Lungs: ____

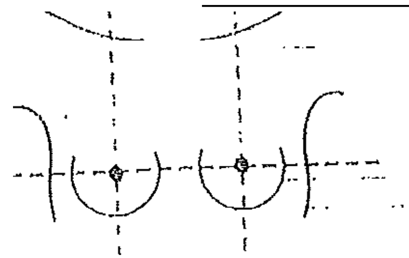
____

Heart: ____

____

Breasts & Axillae: ____

____



Peripheral Pulses: ____

____

Abdomen: ____

____

Extremities: ____

____

Neurological: ____

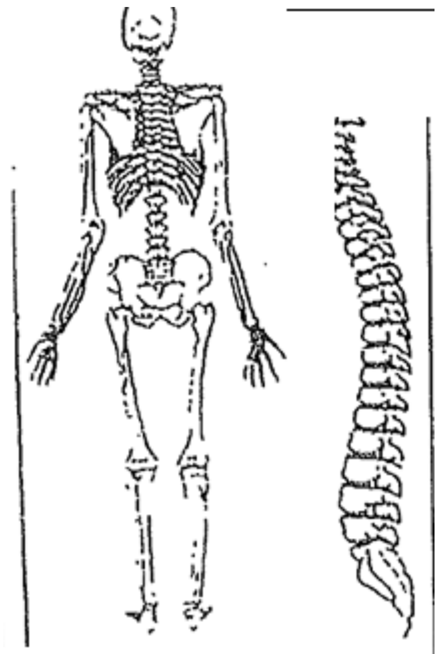
____

Musculoskeletal: ____

____

****

ASSESSMENT:



****

TREATMENT or DIAGNOSIS PLAN: (if applicable)

****

Physician's Name (PLEASE PRINT): ______________________________

Physician's Signature: ______________________________

Date: ______________________________

Physician's Address (PLEASE PRINT): ______________________________

____

____