Pre-Registration Information for Non-Clinical Students

Welcome to Columbia University Irving Medical Center (CUIMC)! Student Health on Haven looks forward to supporting your health and well-being during your time at CUIMC.

In order to register for classes, you must complete the pre-registration process. The information listed below highlights each step of the pre-registration process. Incomplete information will result in a delay in your ability to register for classes.

Visit **studenthealth.cuimc.columbia.edu** for additional information on pre-registration health requirements for students enrolled in non-clinical programs.

If you have any questions about the pre-registration requirements, email shsregistration@cumc.columbia.edu.

Step 1: Log into our Student Health Portal* using your new Columbia UNI: https://portal.studenthealth.cuimc.columbia.edu.

- Once logged in, navigate to "Medical Clearances" and complete the **Health History**, **Meningitis Decision**, **Insurance Verification**, **Notice of Privacy Practice** forms, and the **Tuberculosis (TB) Screening**.

Step 2: Fill out your information at the top of the Pre-Registration Immunization form and have a medical provider complete the rest of the form.

- Under the TB Screening, if you **screened positive for TB risk**, **have a positive test, or have a history of a prior positive test,** please have your medical provider complete the appropriate supplemental sections on the immunization form.

Step 3: Upload a copy of your completed and signed form to the Student Health Portal.

- Navigate to "Medical Clearances" and select "Imm Form - Non-Clinical" to upload the appropriate documentation.
- Enter all vaccine dates in the applicable fields.

**All information stored in the online Student Health portal is confidential and a part of your medical record. It will be stored in a secure, confidential electronic medical record system accessible only to Student Health on Haven staff.*

Pre-Registration Immunization Form for Non-Clinical Students

An MD/DO, NP, or PA who is not a relative must complete this form. Please attach immunization records, and copies of **all titers, antigens, and x-rays**. All reports must be submitted in English. Failure to do so will result in registration delays. **Only this form will be accepted as proof of immunization.**

Last Name	______	**First Name**	______	**Middle Initial**	______
UNI	______	**Date of Birth**	______	**School/Program**	______
Full-time	______	**Part-Time**	______	**Telephone Number**	______

Measles (Rubeola), Mumps, Rubella (MMR): *Two doses of MMR vaccine (after 1 year of age) OR two doses of measles vaccine, two doses of mumps vaccine, and one dose of rubella vaccine OR positive titers (IgG) showing immunity to measles, mumps, and rubella*

	Vaccine/Titer	Date	Result	Copy Attached
Option A MMR Immunizations *(On or after first birthday and at least 28 days apart)*	MMR Dose 1		N/A	
	MMR Dose 2			
Option B Positive MMR IgG Antibody titers *(lab reports required)*	Measles (*Rubeola*) Titer			**Lab Report Required**
	Mumps Titer			**Lab Report Required**
	Rubella Titer			**Lab Report Required**
Option C Measles, Mumps and Rubella Immunizations *(On or after first birthday and at least 28 days apart)*	Measles Dose 1		N/A	
	Measles Dose 2			
	Mumps Dose 1			
	Mumps Dose 2			
	Rubella Dose 1			

Meningococcal Decision: *After completing the Online Meningitis Decision form, please choose one of the following options.*

Option A	If you received the meningitis vaccine (ACWY) in the past 5 years or have completed the 2- or 3-dose series for Meningitis B vaccine, please document it here, **enter the date and submit your documentation on the portal.**	**Date:**
Option B	If you intend to get the meningitis vaccine (MenACWY), you will have 30 days from the start of the semester to complete this requirement.	
Option C	If you are declining the meningitis vaccine, there is no further action to take once you've completed the decision form in the portal.	

Name____UNI ________________

<table>
<tr><th colspan="5">Tuberculosis Screening: All students should complete Section A. If you screen positive for TB risk, you must complete Sections B, C, or D, depending on which is applicable.</th></tr>
<tr><td>Section A:
TB Risk Screening Result

Select the option that reflects the TB risk screening you completed on the Student Health Portal.</td><td>I screened positive for TB risk and do not have a prior history of positive TB test.

You must complete Section B.</td><td>I screened positive for TB risk and have a prior history of positive TB tests.

You must complete Section C.</td><td>I screened negative for TB risk.

You are finished with this section. Skip to “Additional Requirements” section.</td><td></td></tr>
<tr><td rowspan="2">Section B:
No Prior Positive Test

Documentation of a test reported within six months of program start date.</td><td>Test</td><td>Date</td><td>Result</td><td>Copy Attached</td></tr>
<tr><td>IGRA Blood Test:

QuantiFERON

T- SPOT</td><td></td><td>If positive, complete Section C.</td><td>Lab Report Required</td></tr>
<tr><td rowspan="5">Section C:
History of Prior Positive Test (recent or past)

Complete this section only if you have a positive test or a history of a prior positive test.</td><td>Test</td><td>Date</td><td>Result/Reading</td><td>Copy Attached</td></tr>
<tr><td>POSITIVE skin test*
(reading > 10 mm)</td><td></td><td>mm</td><td>N/A</td></tr>
<tr><td>Positive IGRA Blood Test (QuantiFERON or T-SPOT testing)</td><td></td><td></td><td>Lab Report Required</td></tr>
<tr><td>Report</td><td>Date</td><td>Normal/Abnormal</td><td>Copy Attached</td></tr>
<tr><td>Chest X-ray Report (required)

Chest x-ray should be dated after the date of the positive test.</td><td></td><td></td><td>Report Required</td></tr>
<tr><td rowspan="4">Prophylactic Medications for Latent TB Taken</td><td>Yes</td><td></td><td>No</td><td></td></tr>
<tr><td>Date Started</td><td></td><td>Date Ended</td><td></td></tr>
<tr><td>Medications Taken</td><td colspan="3"></td></tr>
<tr><td>Length of Treatment</td><td colspan="3"></td></tr>
<tr><td rowspan="4">Section D:
History of Active TB (recent or past)</td><td colspan="2">Date of Diagnosis</td><td colspan="2">Date Treatment Completed</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Chest X-Ray Report</td><td>Date</td><td>Normal/Abnormal</td><td>Copy Attached</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>

Name____UNI ________________

Recommended Vaccinations:

Influenza: *Columbia University recommends that students receive or provide documentation they have received the seasonal influenza vaccine between August 1 of the Fall term and May 1 of the Spring term.*				
Submit the date of your most recent vaccine	**Vaccine**	**Date**	**Result**	**Copy Attached**
			N/A	**N/A**

I attest that all dates, results, and immunizations listed on this form are correct and accurate.

Provider's Printed Name____Date__________________________

Provider's Signature____License Number_________________

Clinician/Practice Stamp *(required)*