

## Pre-Registration Information for 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](https://studenthealth.cuimc.columbia.edu) for additional information on pre-registration health requirements for students enrolled in clinical programs.

If you have any questions about the pre-registration requirements, email [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu).

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### 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, Insurance Verification**, and the **Notice of Privacy Practices**.
- Additionally, submit proof of your **COVID-19 Vaccination** (*scan of a completed vaccine card*) and **Influenza Vaccination** (*during flu season*).

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### Step 2: Complete your Meningitis Decision.

- Under the “Medical Clearances,” complete the **Meningitis Decision**.
- If you select that you **received the meningitis vaccine in the past 10 years**, you also will need to take additional steps under Medical Clearances to list the vaccination date and upload your supporting documentation.

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### Step 3: Upload a copy of your completed and signed form to the [Student Health Portal](#).

- Navigate to “Medical Clearances” and select “**Imm Form - 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 Clinical Students

**This form must be completed by an MD/DO, NP, or PA who is not a relative.** Attach physical exam, immunization records, and **copies of all laboratory and x-ray reports**. You must submit all reports in English; failure to do so will result in registration delays. All items are required as written below. **Only this form will be accepted as proof of immunization.**

Visit the [Student Health on Haven website](#) for additional information on pre-registration health requirements for clinical students.

### This section is to be completed by the student:

<b>Last Name</b>	_____	<b>First Name</b>	_____	<b>Middle Initial</b>	_____
<b>UNI</b>	_____	<b>Date of Birth</b>	_____	<b>School/Program</b>	_____
<b>Full-time</b>	_____	<b>Part-Time</b>	_____	<b>Telephone Number</b>	_____

### This section is to be completed by a medical provider:

<b>Hepatitis B:</b> Documentation of <b>complete</b> Hepatitis B series <b>AND</b> a positive <b>quantitative</b> Hepatitis B surface antibody titer at least 30 days after last dose. Visit <a href="http://www.cdc.gov/vaccines/vpd/hepb/hcp/">www.cdc.gov/vaccines/vpd/hepb/hcp/</a> for additional information.				
<b>Option A</b> Hepatitis B vaccine, Hepatitis B surface antibody titer >10 mIU/mL, and Hepatitis B antigen titer (if Hepatitis B surface antibody is negative).  <i>If you completed the Hepatitis B series and your titer is &lt;10 mIU/mL one to two months after your last vaccine, you will require additional doses.</i>  <i>Also, submit the date of the previous immunizations and negative/non-reactive titer. If you have already received two full courses of Hepatitis B vaccination, submit the dates of ALL doses of vaccine and negative titers.</i>	<b>Vaccine</b>	<b>Date</b>	<b>Vaccine (if necessary)</b>	<b>Date</b>
	<b>Heplisav-B</b>			
	Dose 1		Dose 3 (if necessary)	
	Dose 2		Dose 4 (if necessary)	
	<b>OR</b>			
	<b>Engerix-B or Recombivax-HB</b>			
	Dose 1		Dose 4 (if necessary)	
	Dose 2		Dose 5 (if necessary)	
	Dose 3		Dose 6 (if necessary)	
	<b>AND</b>			
	<b>Titer</b>	<b>Date</b>	<b>Result</b>	<b>Copy Attached</b>
	Hepatitis B Surface Antibody Quantitative			<b>Lab Report Required</b>
	Hepatitis B Surface Antigen (if Hepatitis B surface antibody is negative)			<b>Lab Report Required</b>
	<b>Option B</b> History of Hepatitis B infection  <i>If BOTH of these titers are negative you should be immunized and check the surface antibody titer one to two months after last dose of vaccine</i>	Hepatitis B Core Antibody Quantitative*		
Hepatitis B Surface Antigen titer*				<b>Lab Report Required</b>
<b>* Within Six Months of Start Date</b>				

**Hepatitis C:** Hepatitis C antibody within 6 months of program start date (lab report required). If hepatitis C antibody is positive, a quantitative hepatitis C RNA test is required.

	Titer	Date	Result	Copy Attached
	Hepatitis C IgG titer			Lab Report Required
<b>Only if IgG Positive</b>	Hepatitis C Quantitative RNA			Lab Report Required

**Measles (Rubeola), Mumps, Rubella (MMR):** Two doses of MMR vaccine (after first birthday) 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

Option A	Vaccine/Titer	Date	Result	Copy Attached
MMR Immunizations (On or after first birthday and at least 28 days apart)	MMR Dose 1		N/A	
	MMR Dose 2			
<b>Option B</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
<b>Option C</b> 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			

**Polio:** Documented date of most recent IPV (killed) or OPV (live) polio vaccine recommended (not required)

	Vaccine	Date	Check One	Copy Attached
	Dose		IPV      OPV	N/A

**Tetanus, Diphtheria, Acellular Pertussis:** One-time dose of Tdap vaccine required regardless of the date of last tetanus shot; tetanus boosters every 10 years thereafter

	Vaccine	Date	Result	Copy Attached
	Tdap (required)		N/A	
	Td/Tdap vaccine dose (if more than 10 years since last Tdap)			

**Tuberculosis Screening:** IGRA blood test (QuantiFERON Gold) within 6 months of program start date. If positive, submit a chest x-ray report. Only QuantiFERON will be accepted; TB skin tests will not be accepted.

Option A	Test	Date	Result/Reading	Copy Attached
No Prior Positive Test Documentation of a negative test reported within six months of program start date (lab report required)	IGRA Blood Test (QuantiFERON):			Lab Report Required
<b>Option B</b> History of Prior Positive Test (recent or past)  <i>* History of latent TB, positive skin test, or positive blood test</i>  <i>** Chest x-ray should be dated after the date of the positive test.</i>	POSITIVE skin test* (reading > 10 mm)		mm	N/A
	Positive IGRA Blood Test (QuantiFERON)			Lab Report Required
	<b>Report</b>	<b>Date</b>	<b>Normal/Abnormal</b>	<b>Copy Attached</b>
	<b>Chest X-ray Report** (required)</b>			Report Required
<b>Prophylactic Medications for Latent TB Taken</b>	Yes		Date Started	
	No		Date Ended	
	Medications Taken			
	Length of Treatment			
<b>Option C</b> History of Active TB (recent or past)  <i>** Chest x-ray should be dated after the date of the positive test.</i>	Date of Diagnosis		Date Treatment Completed	
	Report	Date	Normal/Abnormal	Copy Attached
	<b>Chest X-ray Report** (required)</b>			Report Required
<b>Varicella:</b> Two doses of Varicella vaccine ( <u>after first birthday</u> ) OR positive Varicella IgG antibody titer				
<b>Option A</b> Varicella Immunizations (two doses required at least 28 days apart)	Vaccine/Titer	Date	Result	Copy Attached
	Dose 1		N/A	N/A
	Dose 2			
<b>Option B</b> Positive Varicella IgG Antibody titer	Varicella Titer			Lab Report Required

Name \_\_\_\_\_ UNI \_\_\_\_\_

**Additional requirements:**

<b>COVID-19 Vaccine/Booster:</b> <i>Columbia University requires that all clinical students must provide documentation of a primary series of a COVID-19 vaccine authorized/approved by the US Food and Drug administration or the World Health Organization.</i>				
Vaccine	Vaccine/Booster	Date	Result	Copy Attached
<b>Booster</b> <i>Recommended but not required</i>			N/A	Copy of Vaccination Card Required
<b>Influenza:</b> <i>Columbia University policy states 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.</i>				
Submit the date of your most recent vaccine	Vaccine	Date	Result	Copy Attached
			N/A	N/A
<b>Meningococcal Decision:</b> <i>After completing the Online Meningitis Decision form, please choose one of the following options.</i>				
Option A	If you received the meningitis vaccine (MenACWY) in the past 10 years, please document it here, <b>enter the date and submit your documentation on the portal.</b>		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.			

**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)