HEBREW UNION COLLEGE – JEWISH INSTITUTE OF RELIGION

היברו יוניון קולג - מכון למדעי היהדות

REQUIRED MEDICAL FORMS

Please return the following:

- Medical Form Part One
- Medical Form Part Two
- Immunization Record
- Meningococcal Response Form

Mail to:

National Office of Recruitment and Admissions
Hebrew Union College – Jewish Institute of Religion
3101 Clifton Avenue
Cincinnati, OH 45220-2488

or

Email: admissions@huc.edu

All forms must be received by HUC-JIR before students are given permission to register for classes.

Hebrew Union College – Jewish Institute of Religion
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MEDICAL FORM – Part 1

STUDENT'S MEDICAL HISTORY

(To be completed by the *Student*)

INSTRUCTIONS: Please complete your medical history and return this form by mail or scanned email by to:

Hebrew Union College-Jewish Institute of Religion
National Office of Recruitment and Admissions
3101 Clifton Avenue
Cincinnati, OH 45220-2488
admissions@huc.edu

STUDENT'S NAME ____
(Print) Last First Middle

ADDRESS ____
Street City State Zip Code

PHONE ____________________ DATE OF BIRTH ______________ COUNTRY OF BIRTH ______________

IN CASE OF EMERGENCY, CONTACT ______________________ RELATIONSHIP ______________

ADDRESS ____
Street City State Zip Code

PHONE (business)______________ PHONE (residence) ______________ PHONE (cell)______________

STUDENT'S SIGNATURE: ______________________________________ Date: ______________

FAMILY HISTORY

CHECK EACH ITEM	*YES*	*NO*	*RELATIONSHIP*	*CHECK EACH ITEM*	*YES*	*NO*	*RELATIONSHIP*
TUBERCULOSIS (If Yes, Give Details Below, Year Exposed & X-Ray)				STROKE			
DIABETES				ASTHMA, HAY FEVER, HIVES			
HIGH BLOOD PRESSURE				EPILEPSY OR CONVULSIONS			
HEART TROUBLE				NERVOUS OR MENTAL DISEASE			
MOTHER LIVING?				DRUG OR ALCOHOL ADDICTION			
FATHER LIVING?				CANCER			
NO. OF BROTHERS LIVING? __NO. OF SISTERS LIVING?			IF DECEASED, GIVE RELATIONSHIP AND CAUSE OF DEATH				

HAVE YOU EVER HAD OR HAVE YOU NOW ANY OF THE FOLLOWING: (IN LINES OF MULTIPLE STATEMENTS, CROSS OUT THE INAPPLICABLE WORDS.) EXPLAIN ALL POSITIVE ANSWERS BELOW.

CHECK EACH ITEM:	*YES*	*NO*		*YES*	*NO*		*YES*	*NO*		*YES*	*NO*
HEART TROUBLE			WEAR GLASSES			TUBERCULOSIS			SWOLLEN OR PAINFUL JOINTS		
HIGH OR LOW BLOOD PRESSURE			NOSE OR THROAT TROUBLE			STOMACH OR INTESTINAL TROUBLE			LAMENESS, PARALYSIS, POLIO		
RHEUMATIC FEVER			EAR TROUBLE (OTITIS)			JAUNDICE OR LIVER DISEASE			MOTION SICKNESS (TRAIN, CAR, ETC)		
SCARLET FEVER			SINUSITIS			APPENDICITIS			DIZZY OR FAINTING SPELLS		
DIPHTHERIA			CHRONIC OR FREQUENT COLDS			HERNIA			EPILEPSY		
MUMPS			HAY FEVER, ALLERGY			SKIN DISEASES, BOILS			CONVULSIONS		
WHOOPING COUGH			ASTHMA			PAINFUL OR TRICK SHOULDER			NERVOUS TROUBLE (ANY KIND)		
MEASLES			REACTION TO SERUM OR DRUGS			TRICK OR LOCKED KNEE			SUGAR OR ALBUMIN IN URINE		
CHICKENPOX			CHRONIC COUGH			LOSS OF ARM, LEG, FINGER, OR TOE			KIDNEY TROUBLE		
MONONUCLEOSIS			SHORTNESS OF BREATH			BONE OR JOINT DEFORMITY			DIABETES		
CANCER			PSYCHOLOGICAL DISORDER			ADDICTION			OTHER		

IF YES, OR ANY OTHER DISEASE OR CONDITIONS, GIVE DETAILS:______________________________

____

____

HAS YOUR HEALTH BEEN _____GOOD _________ FAIR ________POOR IF NOT GOOD, EXPLAIN ______________________________

_____

____

____

CHECK EACH ITEM:	YES	*NO*	*IF YES, EXPLAIN BELOW, PLEASE NUMBER ANSWERS.*
1. HAVE YOU EVER BEEN REFUSED EMPLOYMENT OR EVER BEEN UNABLE TO HOLD A JOB BECAUSE OF YOUR HEALTH?			
2. HAVE YOU BEEN UNABLE TO TAKE PHYSICAL EDUCATION OR PARTICIPATE IN SPORTS BECAUSE OF YOUR HEALTH?			
3. HAVE YOU BEEN DENIED LIFE INSURANCE OR REJECTED FOR MILITARY SERVICE BECAUSE OF YOUR HEALTH?			
4. HAVE YOU CONSULTED OR BEEN TREATED BY A CLINIC OR PHYSICIAN IN THE PAST 5 YEARS FOR REASONS OTHER THAN ROUTINE CHECKUPS?			
5. HAVE YOU EVER HAD ANY SERIOUS ILLNESS, INJURY, OR OPERATION NOT LISTED ABOVE?			
6. ARE YOU TAKING ANY MEDICATION REGULARLY?			
7. HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL OR EMOTIONAL			

CHECK EACH ITEM:	YES	*NO*	*IF YES, EXPLAIN BELOW, PLEASE NUMBER ANSWERS.*
ILLNESS? WHEN? WHERE?			
8. HAVE YOU EVER HAD TO DISCONTINUE STUDY OR WORK FOR ANY PERIOD OWING TO PHYSICAL ILLNESS, NERVOUS DISTURBANCES?			
9. HAVE YOU EVER PARTICIPATED IN A DRUG OR ALCOHOL RECOVERY PROGRAM?			

Student's Last Name:

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MEDICAL FORM – Part 2

(To be completed by the *Physician*)

INSTRUCTIONS: Please complete "Physical Examination" and "Immunization" sections and return form by mail or scanned email to:

Hebrew Union College-Jewish Institute of Religion
National Office Recruitment and Admissions
3101 Clifton Avenue
Cincinnati, OH 45220-2488
admissions@huc.edu

PHYSICAL EXAMINATION

STUDENT'S NAME ____ Date ____________
(Print) Last First Middle

1. GENDER _____ HEIGHT __________ BUILD: SLENDER ________ HEAVY ______ BLOOD PRESSURE _________
AGE _____ WEIGHT __________ MEDIUM ________ OBESE ______ PULSE _________

2. VISION: WITH GLASSES: HEARING:
RIGHT 20/ _________ RIGHT 20/ _________ COLOR VISION ____________________ RIGHT _______/15
LEFT 20/ _________ LEFT 20/ _________ TEST USED ____________________ LEFT _______/15
IF CORRECTION IS NEEDED, PLEASE REFER IMMEDIATELY.

IMMUNIZATION

IT IS REQUIRED THAT ALL INCOMING STUDENTS BE IMMUNIZED AGAINST MEASLES, MUMPS, AND RUBELLA (MMR). PERSONS BORN PRIOR TO JANUARY 1, 1957 ARE EXEMPT FROM THIS REQUIREMENT.

MUMPS

Date of Illness __________ or
Date of Immunization __________ or
Date of Antibody Titer __________ Results __________

MEASLES

Date of Illness __________ or
Date of Immunization, #1__________ #2 __________
Date of Antibody Titer __________ Results __________
(Both must be after 1968; #1 must be 12 months from birth or later and #2 must be at least one month from the first)

RUBELLA

Date of Immunization __________ or
Date of Antibody Titer __________ Results __________
(Diagnosis of the disease is not acceptable)

M.M.R. (MEASLES, MUMPS AND RUBELLA)

Date of 1st Immunization __________
(must be 12 months after birth or later but before five years of age)

Date of 2nd Immunization __________
(must be at lease one month from the first)

CLINICAL EVALUATION

CHECK EACH ITEM IN PROPER COLUMN. ENTER "NE" IF NOT EVALUATED.	NORMAL	ABNORMAL	NOTE: GIVE DETAILS OF EACH ABNORMALITY. ENTER CORRESPONDING ITEM NUMBER BEFORE EACH COMMENT.
3. HEAD, NECK, FACE, AND SCALP			
4. NOSE AND SINUSES			
5. MOUTH, TEETH, GINGIVA, AND THROAT			
6. EARS -- GENERAL (CANALS, DRUMS, ETC.)			
7. EYES -- GENERAL (LIDS, PUPILS, MOTIONS, ETC.)			
8. LUNGS, CHEST, AND BREASTS			
9. HEART (INCLUDES ESTIMATE OF CARDIA FUNCTION)			
10. VASCULAR SYSTEM (INCLUDE VARICOSITIES)			
11 ABDOMEN AND VISCERA (INCLUDE HERNIA)			
12. ANO-RECTAL AND PILONIDAL			
13. ENDOCRINE SYSTEM			
14. GENITO-URINARY SYSTEM			
15. UPPER EXTREMITIES			
16. LOWER EXTREMITIES (INCLUDE FEET)			
17. SPINE, OTHER MUSCULOSKELETAL			
18. SKIN AND LYMPHATIC (INCLUDE ACNE)			
19. NEUROLOGICAL SYSTEM			
20. PSYCHIATRIC (SPECIFY ANY PERSONALITY DEVIATION)			

21. If female, please note any gynecologic problems ________________________________

22. Urinalysis: Albumin__________ Sugar_________ Special tests used in clinical evaluation (blood, EKG, etc)____________________

23. **If necessary**, Report and Date of recent chest x-ray ________________________________

24. Consultation used or indicated (dental, oculist, etc.) ________________________________

25. Any drug allergies ________________________________

26. Is this individual capable of normal physical activity? (Athletics, hiking, rugged travel?) ____________________

    If not, give reasons and limitations. ________________________________

27. Do you consider the student's health to be such that it would allow him or her to stand the rigors of an academic course of study? ____________________

COMMENTS: ________________________________

____

____

____

Student's Last Name:

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Student Immunization Record

In order to maintain the health of all students: public health law requires that students attending postsecondary institutions in the state submit proof of immunization against certain vaccine preventable diseases. Hebrew Union College students may demonstrate immunity by presenting proof of having received two (2) vaccinations for Rubeola (Measles), two (2) vaccinations for Mumps, and at least one vaccination for Rubella (German Measles) or if given in combination, two (2) M-M-R (Measles, Mumps and Rubella) vaccines. Immunity may also be affirmed by providing the results of a laboratory test (immune titer) for each disease.

Student's Name	Date of Birth	Campus

Mandatory Immunizations

Two Measles Mumps and Rubella (MMR) vaccinations
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date________________
- Date 2: Immunization 15 moths after birth and at least 28 days after 1st vaccination — Date________________
- If born **before** 1957, indicate birth date — Date________________

OR

Two Measles (Rubeola) vaccinations
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date________________
- Date 2: Immunization 15 moths after birth and at least 28 days after 1st vaccination — Date________________
- Date of positive immune titer — Date________________

Rubella (German Measles) vaccination
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date________________
- Date 2: Immunization 15 moths after birth and at least 28 days after 1st vaccination — Date________________
- Date of positive immune titer — Date________________

Other Vaccines (Recommended by not mandatory for Admission)

Tetanus, Diphtheria, Pertusis (primary series completed) — Date________________
Last booster (within 10 years)
Date________________

Hepatitis A Series First_______________ Second_______________
Hepatitis B Series First_______________ Second_______________ Third_______________

Varicella (Chicken Pox) Vaccine — Date________________
Positive immune titer to Varicella — Date________________

OR

Date Varicella was diagnosed — Date________________

Polio (if primary series completed, list the last booster) — Date________________

Tuberculosis skin test — Date________________ Result: □ neg □ pos
If positive, date of chest X-ray — Date________________ Result: □ neg □ pos
If positive, was prophylaxis given? □ yes □ no — Dates: from__________ to___________

Physician Signature	Physician Stamp (office stamp required)
Date	

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MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to the Office of the National Registrar within thirty (30) days, or they will be blocked from registration and from attending classes.

Campus	Major		Term/Year	
Last Name	First		Middle	Maiden
Address				
City		State	Zip Code	
Phone ( )	Email Address		Date of Birth	

CHECK ONE BOX AND SIGN BELOW:

I have (for students under the age of 18: My child has):

☐ had the Meningococcal Meningitis immunization within the past 10 years.
Date received______________________________.

☐ received the information regarding Meningococcal disease and vaccine, including information regarding the availability and cost of the Meningococcal Meningitis vaccine.
I have decided that I (my child) will not obtain immunization against Meningoccal Meningitis disease.

☐ received the information regarding Meningococcal disease and vaccine, including information regarding the availability and cost of the Meningococcal Meningitis vaccine.
I will obtain immunization against Meningococcal Meningitis disease within thirty (30) days.

Student Signature	Date

Parent/Guardian Signature (if student is a minor)	Date

Meningococcal Meningitis Disease Information Sheet

What is meningococcal disease?
Meningococcal disease (commonly referred to as meningitis) is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshman living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as a result of infection. Other persons at increased risk include household contacts of a person known to have had this disease, immuno-compromised persons, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcal spread?
The meningococcus germ is spread by/through the air via respiratory secretions such as coughing, sneezing, kissing , or sharing of personal items like utensils, cigarettes, and drinking glasses. Many people carry this particular germ without any signs of illness, while others may develop serious symptoms.

What are the symptoms?
High fever headache, vomiting, stiff neck, and a rash are symptoms of meningococcal disease. Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, kidney failure, seizures, chronic nervous system problems, loss of limbs, and even death.

How soon do the symptoms appear?
The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?
Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups, A,C, Y, W-135) that cause about 70% of the disease in the United States.

Is the vaccine safe? Are there adverse side effects to the vaccine?
The vaccine is safe with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions, but the risk of the meningococcal vaccine causing serious harm is small.

What is the duration of protection from the vaccine?
After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect all susceptible individuals.

Where can I obtain the vaccine?
The College does not offer meningococcal vaccine services through the campus health service center. Students who would like to receive the vaccines should consult with their primary care physician or a traveler's clinic. The cost of the vaccine varies, but prices quoted have ranged from $75 - $100.

How do I get more information about meningococcal disease and vaccination?
Contact your family physician or health provider. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/; and the American College Health Association, www.acha.org.

Hebrew Union College-Jewish Institute of Religion
Annual Notification Re: Drug-Free Campus
Policy and Procedures

Purpose

Hebrew Union College-Jewish Institute of Religion is required to establish an institution-wide policy that promotes a drug-free and alcohol-free workplace in compliance with the Drug-Free workplace Act of 1988 and the Drug-Free Schools and Communities Act of 1989.

Policy

The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance, illicit drug or alcohol in and on the property of the Hebrew Union College-Jewish Institute of Religion or as a part of any College-Institute activity is prohibited. Any student, faculty, or staff member who is determined to have violated this policy shall be subject to disciplinary action up to and including discharge and/or expulsion. The College-Institute will comply with all statutory and regulatory requirements, including those for information and notification.

Procedure

1. The College-Institute is required to inform the entire College community of the applicable legal sanctions under local, state or federal law for the unlawful possession or distribution of illicit drugs and alcohol. These are described on Appendix A (attached).

2. We believe that the health risks associated with the use of illicit drugs and in the abuse of alcohol are well known to the members of our College community. We also call to your attention Appendix B (attached) which lists the uses and effects of controlled substances.

3. The College-Institute does not itself maintain services for drug counseling or rehabilitation. College community members are strongly encouraged to be aware of and/or to take advantage of the many assistance programs available in our community. See Appendix C (attached) for a listing of services and phone numbers.

4. The law requires that an HUC-JIR student, faculty, or staff member must notify the College-Institute of any criminal drug statute conviction for a violation occurring on the campus or as part of College-Institute activity not later than five days after such conviction. Any person who is convicted of such offense will be subject to discipline as described above and/or be required to participate in a drug/alcohol abuse assistance or rehabilitation program.

THIS NOTIFICATION IS ISSUED AS A SUPPLEMENTARY PART OF CURRENTLY EXISTING REGULATIONS WHICH APPEAR IN THE STUDENT AND STAFF HANDBOOKS.