



ACADEMIC BACKGROUND

List all postsecondary institutions attended, including Touro College if applicable. List the most recent first. Use a supplemental sheet if needed.

Name of Institution	City, State	Dates of Attendance (mm/yy)	Degree (BA, MS, etc)	Date of degree award (mm/yy)	Cumulative GPA (4.0 scale)
_____	_____	From _____ To _____	_____	_____	_____
_____	_____	From _____ To _____	_____	_____	_____
_____	_____	From _____ To _____	_____	_____	_____

PROFESSIONAL BACKGROUND

Do you hold any professional certification? Yes No If yes, provide the following details:

Title	Issued by	Date issued	Date of expiration
_____	_____	_____	_____
_____	_____	_____	_____

SPECIAL DEMOGRAPHIC DATA

The information requested below is being collected from U.S. citizens and permanent residents to meet research and federal reporting requirements. It is confidential and will be released only as statistical summaries in which individuals are not identified. Response is voluntary. The information has no bearing on either admission or academic decisions.

- Are you Hispanic or Latino? Yes No
- Please choose one or more of the following groups to describe your race:

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black or African American	

STATEMENT OF CERTIFICATION

I certify that all information supplied in this application is true and complete to the best of my knowledge. I understand that withholding or giving false information will make me ineligible for admission to Touro College. I also understand that the application fee may not be waived nor is it refundable, and that the application and supporting documents become the property of Touro College and cannot be returned.

Signature _____ Date _____

Touro College does not discriminate on the basis of race, sex, color, national origin, religion, marital status, age, sexual orientation, gender identity, veteran or military status, disability, genetic information, or any other characteristic protected by law in employment, or in its admission, treatment or access to its educational programs or activities.

FOR OFFICE USE ONLY	
Program Chair	Admissions
<input type="checkbox"/> Admit <input type="checkbox"/> Pending <input type="checkbox"/> Deny	Entered By:
Program Code:	Date:
Signature:	Signature:





This form is to be completed by all students born on or after January 1, 1957.

PERSONAL INFORMATION (To be completed by the student)

Name _____ / _____ / _____
First Last Middle (complete) Date of Birth

Social Security Number _____ Touro I.D. (if any) _____ Prog/Ext _____

MAILING ADDRESS

Number and Street _____ Apartment # _____ City _____ State _____ Zip/Postal Code _____

Day Phone (_____) _____ Evening Phone (_____) _____

Check at least one of the statements below.

- Vaccination Record below is complete for each disease. I have no acceptable alternate record or exemptions to submit.
- Alternate records are attached for each disease.
- Medical Exemption on reverse is complete for each vaccination for which I claim medical examination.

_____ / _____ / _____
Signature Date

VACCINATION RECORD (To be completed by the health practitioner)

	Measles	Rubella	Mumps	or Combined MMR
Vaccination Date <small>(Two doses required for Measles or MMR)</small>	Dose 1 _____	_____	_____	_____
	Does 2 _____	_____	_____	_____
Disease history <small>(Date of Onset)</small>	_____	_____	_____	_____
	_____	_____	_____	_____
Serology Date and Results <small>(Indicate + or -) Include copy of lab report</small>	_____	_____	_____	_____
	_____	_____	_____	_____
Scheduled Date for Dose 2	_____	_____	_____	_____

Important Note About Revaccination:

Measles—If administered prior to 1968 and not specified as “live” and/or if student was less than 12 months of age for first dose and/or less than 15 months of age for second dose, vaccination must be repeated. Indicate date for follow-up. Mumps and Rubella—If vaccination was given prior to 1969 and/or if patient was less than 12 months of age, vaccination must be repeated.

I certify that the above information is correct. (Must be signed by health practitioner)

_____ / _____ / _____
Signature Name / Title Date

_____ (_____) _____
Clinic Address Phone





MEDICAL EXEMPTION FROM IMMUNIZATION (To be completed by the health practitioner)

I certify that it is medically contraindicated for the above named person to be vaccinated for the disease(s) indicated below because of the stated medical reasons. (Reason and expiration date—or state if permanent—required for each disease.)

Check disease(s)—indicate medical reason(s) for contraindication

Valid through date

- Measles — _____ / ____ / ____
- Mumps — _____ / ____ / ____
- Rubella — _____ / ____ / ____

Must be signed by health practitioner to be acceptable.

 _____ / ____ / ____
Signature *Name/Title* *Date*

Clinic *Address* *(Phone)*

MENINGITIS VACCINATION RESPONSE (To be completed by student)

In accordance with New York State Public Health Law, Touro College requires that all students complete and return the following form to Touro College.

Check one box and sign below.

I have:

- had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
 Date received _____ / ____ / ____

{Note: If you received the meningococcal vaccine available before February 2005, called Menomune™, please note this vaccine's protection lasts for approximately 3-5 years. Revaccination with the new conjugate vaccine, called Menactra™, should be considered within 3-5 years after receiving Menomune™.}

- read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis from my private health practitioner or when offered through Touro College.
- read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

 _____ / ____ / ____
Student's Signature (Parent/Guardian if student is under 18) *Date*

Print Student's Name *Student's Date of Birth*

Student's E-mail Address *Student's ID or Social Security #*

Student's Mailing Address *Number and Street* *Apartment* *City*

State *Zip* *() Student's Phone Number*





Meningococcal Disease Notice

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF COMMUNICABLE DISEASE CONTROL

What is meningococcal disease?

Meningococcal disease 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 freshmen 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 result of infection. Currently, no data is available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat 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. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?

The symptoms may appear 2 to 10 days after exposure, but usually within five 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. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. 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 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?

Contact your family physician or your student health service. Additional information is also available on the web sites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention, www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.