

REQUIRED Immunization & Health Information

University at Albany Student Health Center

COMPLETE BOTH SIDES & RETURN IMMEDIATELY, BUT NO LATER THAN JULY 1 FOR FALL ENTERING STUDENTS, DECEMBER 15 FOR SPRING ENTERING STUDENTS (or WITHIN TWO WEEKS OF ADMISSION).

The University Health Center requires the following information be completed for each student in order to attend class at the University at Albany. Complete each “✓” area on the front and back of this form.

YOU DO NOT NEED TO SEE A PHYSICIAN IN ORDER FOR THIS TO BE COMPLETED AND RETURNED.

Student: _____ Birthdate: _____
Last First M.I. Month Day Year

Cell or Preferred Phone Number: () _____ UAlbany ID # _____

Address: _____
Street City State Zip Country

Emergency Contact: _____

Home Phone: () _____ Work Phone: () _____

Are you entering the University as: Undergrad–Freshman Undergrad–Transfer Graduate Student International Student
 Summer Program Student

Note: EVERY “✓” REQUIRES YOUR IMMEDIATE ATTENTION

✓ Measles Mumps Rubella (MMR) Immunization Documentation

Please note that documentation of your MMR vaccinations is REQUIRED in order to attend college in New York State. You are required to have two measles, at least one mumps, and at least one rubella vaccinations. We will accept any one of the following documentations of your MMR vaccinations:

a) A copy of your immunizations on an official government/school letterhead — the simplest place to obtain this may be from your most recently attended high school or college; OR

b) A copy of your immunizations on physician’s letterhead, which includes printed name, address and telephone number; OR

c) Have a blood test to confirm immunity. Please note: a copy of the lab report must accompany this form for acceptance.

Please visit our website for specific information regarding this requirement at: www.albany.edu/health_center/immunization.

This two-sided form, along with your MMR documentation, must be returned to:

University at Albany
University Health Center
Suite 200, 400 Patroon Creek, Albany, NY 12206
Or fax BOTH sides to: 518-442-5444

**RETURN IMMEDIATELY BUT NO LATER THAN JULY 1 FOR FALL ENTERING STUDENTS,
DECEMBER 15 FOR SPRING ENTERING STUDENTS
(or within two weeks of admission)**

Please keep a copy of all sent items for your records. Do not contact us to see if we received your form. You will be notified if you are non compliant.

✓ **Health Questionnaire: Please check the appropriate answer or response.**

- | 1) Have you been or are you currently experiencing any of these symptoms during the past 4 weeks? | Yes | No |
|---|--------------------------|--------------------------|
| Productive cough over 4 weeks | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever (over 100.4) | <input type="checkbox"/> | <input type="checkbox"/> |
| Unplanned weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Nightsweats (persistent, unexplained sweating during sleep) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Have you ever had a positive (indicating previous TB (tuberculosis) exposure) TB skin test (PPD)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you ever been treated for Tuberculosis (TB)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you ever been exposed to anyone sick with Tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Have you ever used illicit or non physician prescribed IV (intravenous) drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Have you ever been a resident or employee of any of the following for greater than 4 weeks? | | |
| Prison/Jail | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing home with direct resident contact | <input type="checkbox"/> | <input type="checkbox"/> |
| Health care facility with direct patient contact | <input type="checkbox"/> | <input type="checkbox"/> |
| Homeless shelter with direct resident contact | <input type="checkbox"/> | <input type="checkbox"/> |
| Yes to any of the above, please provide dates: _____ | | |
| 7) Have you ever been diagnosed with? | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorder (other than anemia, ITP, hemophilia, Von Willebrands)) | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease (other than asthma) | <input type="checkbox"/> | <input type="checkbox"/> |
| Any immunosuppressive disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Have you ever had the following treatments? | | |
| Intestine resection (other than Gastric Stapling) | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral or IV steroid therapy over 4 weeks | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Immunosuppressive drug therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) What country were you born in? | | |
| <input type="checkbox"/> USA <input type="checkbox"/> Other, please provide: _____ | | |
| 10) Have you lived outside of the US for over 4 weeks at any time in your life? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, what country? _____ | | |

Additional Information and dates to explain any yes answer: _____

I certify that the information provided herein is correct. _____ Date: ____/____/____
Signature of student if 18 years of age or older; signature of parent if student under 18 years of age.

✓ **Consent of Parent or Guardian for Treatment of Those Under 18 Years of Age**
To be completed if the student is under 18 years of age at the time of arrival on campus or even if student will turn 18 during the academic year.

To procure care that may be necessary for our students and to protect the physicians and institutions involved, it is necessary that you sign the consent for treatment statement. While every reasonable effort is made to contact families in the event of serious illness or injury, this is not always possible within a short period of time; therefore, the consent form is necessary to provide appropriate care.

I, _____ (Print Full Name of Parent/Guardian) pursuant to the authority vested in me as Parent/Guardian of _____ (Print Full Name of Student), do hereby authorize the Medical Staff of the University at Albany, upon consultation with a practicing physician or surgeon, to exercise for me and in my behalf all my rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines, and hospitalization, including care and treatment by any hospital, staff surgeon, physician, or radiologist which they may deem necessary for the care of my son/daughter (circle one).

Date: ____/____/____

 Legal Signature of Parent/Guardian