



Albany Medical College
Immunization Documentation Form

Part I.
Name: _____ Date of Birth ____ / ____ / ____

Address: _____
(Street) (City) (State) (Zip)

Status: Medical Student ____ Graduate Student ____ NA ____ PA ____

Part II-TO BE COMPLETED AND SIGNED BY THE STUDENT

Meningococcal (One dose within 10 years recommended by NYS PHL § 2167) CHECK ONE (1) BOX ONLY

- Meningococcal Vaccine (**recommended**).....Date ____ / ____ / ____
- I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis **within 30 days**.
- I have 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.

Signed _____ Date _____

Part III-TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required)

1. Dose 1 given at age 12-15 months or later.....#1 ____ / ____ / ____

2. Dose 2 given at age 4-6 years or later, and at least on month after first dose.....#2 ____ / ____ / ____

or

Titer Date(s) (Please attach lab report)

Measles ____ / ____ / ____ Results ____ Mumps ____ / ____ / ____ Results ____ Rubella ____ / ____ / ____ Results ____

B. TETANUS-DIPHTHERIA (Date of most recent booster must be within ten years)..... ____ / ____ / ____

C. VARICELLA (a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirements)

1. Varicella Titer..... ____ / ____ / ____ Reactive ____ Non-reactive ____

or

2. Immunization.....Dose#1 ____ / ____ / ____ Dose #2 ____ / ____ / ____

D. HEPATITIS B.....Dose #1 ____ / ____ / ____ Dose #2 ____ / ____ / ____ Dose #3 ____ / ____ / ____

or

Titer Date..... ____ / ____ / ____ (Please attach lab report)

Name: _____ Date of Birth ____/____/____

E. POLIO (please check the correct vaccination series) OPV IPV/OPV IPV

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____

F. TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is student a member of a high-risk group or is student entering the health profession? Yes _____ No _____
(A history of BCG vaccination does not preclude testing of a member of a high-risk group or students entering the health professions.)
3. Tuberculin Skin Test: Date Given: ____/____/____ Date Read: ____/____/____

Result: _____ mm (Record actual mm of induration, transverse diameter, if no induration, write "0")
- 3a. If blood assay drawn for latent TB infection, specify test _____ date _____ result _____
4. Chest x-ray (required if tuberculin skin test or blood assay is positive) result: normal _____ abnormal _____

Date of chest x-ray ____/____/____
5. Referral made to local health department? Yes _____ No _____

Healthcare Provider Name _____ Date _____

Address: _____ Phone Number (____) _____

Healthcare Provider Signature: _____



ALBANY MEDICAL COLLEGE
PHYSICAL EXAMINATION FORM

Date: _____

Name: _____ DOB: _____

BP: _____ Pulse: _____ Resp: _____ Temp: _____

Visual Acuity

Without glasses or corrected: OD 20/ _____ OS 20/ _____

Physical Exam

	NL	Abnormal		NL	Abnormal
Appearance	___	_____	Heart	___	_____
Skin	___	_____	Lungs	___	_____
Eyes	___	_____	Abdomen	___	_____
Ears	___	_____	Neuro.	___	_____
Mouth and Teeth	___	_____	Periph. Vasc.	___	_____
Nose and Pharynx	___	_____	Hernia N/A	___	_____
Neck/Lymphnodes	___	_____	Back	___	_____
Musculo-skeletal	___	_____			

Comments and Re-checks: _____

To the best of my knowledge this student is healthy and free from communicable diseases. yes no

If no describe: _____

MD/PA/NP Name: _____ Signature: _____

Address: _____

