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

   Immunization……………………Dose #1 ___ / ___ / ___ Dose #2 ___ / ___ / ___

D. HEPATITIS B…..Dose #1 ___ / ___ / ___ Dose #2 ___ / ___ / ___ Dose #3 ___ / ___ / ___

   or

   Titer Date…..___ / ___ / ___ (Please attach lab report)
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 indicted.
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: ____________________________________

Revised 05/08-sm
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

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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: ________________________________________________________________
