REQUIRED Health Form

University at Albany Student Health Services

COMPLETE BOTH SIDES IN BLACK INK AND RETURN.

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: _____

Cell or Preferred Phone Number: ( )

Are you entering the University as: ☐ International 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/immunizationreqs.shtml.**

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

University at Albany
Student Health Services
Suite 200, 400 Patroon Creek, Albany, NY 12206
(518) 956-8400. Or fax BOTH sides to: (518) 442-5444 email: healthforms@albany.edu

Any additional medical summaries (or other pertinent information) that incoming students, parents or medical practitioners view as appropriate for inclusion in the student's UAlbany Student Health Services medical record should be sent directly to the Medical Director for review.

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.

UNIVERSITY AT ALBANY
State University of New York

Please complete BOTH sides of this form.

Student Name: _____ UAlbany ID # _____
Last First M.I.

Health Questionnaire: Please check the appropriate answer or response.

		Yes	No
1)	**Have you been diagnosed with Tuberculosis (TB) within the last five years or had a positive TB test?**	☐	☐
	If yes, approximate date: ____/_____ (month/year); Type of TB: Latent TB: ☐ Active TB ☐		
	Were you treated with anti-TB medication?	☐	☐
	If yes, please provide details: _____		
2)	**Have you used illicit/illegal non-physician prescribed IV (intravenous) drugs in the last 5 years?**	☐	☐
3)	**Have you ever been a resident or employee of any of the following for greater than 4 weeks in the last 5 years?**	☐	☐
	Prison/Jail, nursing home with direct resident contact, health care facility with direct patient contact, homeless shelter with direct resident contact,		
	Yes to any of the above, please provide dates: _____		
4)	**Have you lived outside of the US for over 4 weeks anytime within the past 5 years?**	☐	☐
	If Yes, please list country(ies) and dates of travel or length of stay: _____		
5)	**Have you been or are you now being treated for any chronic medical or psychological problems?**	☐	☐
	If yes, please describe: _____		
6)	**Have you ever been hospitalized or had any surgery?**	☐	☐
	If yes, please describe: _____		
7)	**Do you have allergies to food, medications or latex?**	☐	☐
	If yes, please describe: _____		
8)	**Please list any medications, vitamins, supplements, or birth control that you take on a regular basis (include the name, dose and frequency of the item).** _____		

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