ALBANY COLLEGE OF PHARMACY AND HEALTH SCIENCES

Student Immunization Record

STUDENT INFORMATION (PLEASE TYPE OR PRINT)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

HOME ADDRESS (NUMBER AND STREET)		

CITY	STATE/PROVINCE/COUNTRY	ZIP/POSTAL CODE

LAST 4 DIGITS OF SS#	MOBILE PHONE NUMBER	E-MAIL ADDRESS

Please complete ALL *REQUIRED* items – incomplete forms will affect registration. Please list exact dates (month/day/year). Official immunization/health records can be provided in place of these forms, as long as all requirements are met.

***Cytotechnology* students -** please be sure to complete additional requirement on page 2.

New York State Public Health Law 2165 requires post-secondary students enrolled for at least six (6) semester hours, or the equivalent per semester, to show protection against measles, mumps and rubella. Persons born prior to January 1, 1957 are exempt from this requirement.

■ REQUIRED: Measles (Rubeola) Immunity - must have ONE of the following:

1. **TWO doses of Live Measles Vaccine (or, MMR)** 1st: _____/_____/_____ (M D YY) 2nd: _____/_____/_____ (M D YY)
   *Both must be given after 1967. The first one administered **no more than 4 days prior to the first birthday**, and the second at least 28 days later.*
2. **Measles Titer - *MUST SUBMIT LAB REPORT*** Date: _____/_____/_____ (M D YY) **Results**: ☐ Immune ☐ Not Immune
   If not immune, immunization is required.
3. **Physician-diagnosed Measles disease** Date: _____/_____/_____ (M D YY) AND _____ SIGNATURE OF PHYSICIAN

■ REQUIRED: Mumps Immunity - must have ONE of the following:

1. **At least one Mumps immunization (or, MMR)** 1st: _____/_____/_____ (M D YY) 2nd: _____/_____/_____ (M D YY)
   *Must be administered **no more than 4 days prior to the first birthday**.*
2. **Mumps Titer - *MUST SUBMIT LAB REPORT*** Date: _____/_____/_____ (M D YY) **Results**: ☐ Immune ☐ Not Immune
   If not immune, immunization is required.
3. **Physician-diagnosed Mumps disease** Date: _____/_____/_____ (M D YY) AND _____ SIGNATURE OF PHYSICIAN

■ REQUIRED: Rubella (German Measles) Immunity - must have ONE of the following:

1. **At least one Rubella immunization (or, MMR)** 1st: _____/_____/_____ (M D YY) 2nd: _____/_____/_____ (M D YY)
   *Must be administered **no more than 4 days prior to the first birthday**.*
2. **Rubella Titer - *MUST SUBMIT LAB REPORT*** Date: _____/_____/_____ (M D YY) **Results**: ☐ Immune ☐ Not Immune
   *If not immune, immunization is required. Physician diagnosis is **NOT** acceptable.*

Please be sure to complete and sign page 2 of this form.

LAST NAME FIRST NAME

■ REQUIRED: Varicella (Chicken Pox) Immunity - must have ONE of the following:

1. **Varicella Immunization** 1st: _____/_____/_____ 2nd: _____/_____/_____
   Two doses of the vaccine, given at least one month apart. M D YY M D YY

2. **History of Varicella disease (Chicken Pox)** Date: _____/_____/_____
   M D YY

3. *Recommended:* **Varicella Titer - *MUST SUBMIT LAB REPORT*** Date: _____/_____/_____ Results: ☐ Immune ☐ Not Immune
   If not immune, immunization is required. M D YY

■ REQUIRED: Hepatitis B Immunity - must have ONE of the following:

1. **Dates of Hepatitis B immunizations** 1st: _____/_____/_____ 2nd: _____/_____/_____ 3rd: _____/_____/_____
   M D YY M D YY M D YY

   If not traditional THREE dose series, indicate vaccine type/name: _____

2. **Hepatitis B Titer** Date: _____/_____/_____ Results: ☐ Immune ☐ Not Immune
   MUST SUBMIT LAB REPORT; *If not immune, booster or immunization is required.* M D YY

☐ *Recommended* Vaccines:

- **Tetanus - Diphtheria - Pertussis Booster -** within the last ten (10) years Date: _____/_____/_____
  M D YY

- **Meningococcal Meningitis Vaccine -** 1 dose preferably at entry into college for students living in residence halls who wish to reduce their risk of meningococcal disease. If no immunization within the past **FIVE (5)** years, the ***Meningococcal Disease Vaccination*** form must be completed and signed. Date: _____/_____/_____
  M D YY

■ REQUIRED for CYTOTECHNOLOGY students only: Eye Exam, including color-blindness test; Copy of visual exam report required to be attached

Please let us know if there are any health concerns that you would like to share with us:

_____

_____

IMPORTANT: This form *MUST* be returned to complete your registration. Please return this form to the address below.

Healthcare Provider information and signature or stamp REQUIRED (unless official immunization documentation is provided).

SIGNATURE OR STAMP OF HEALTHCARE PROVIDER PRINTED NAME OF HEATHCARE PROVIDER

ADDRESS

TELEPHONE DATE

RETURN TO:
Albany College of Pharmacy and Health Sciences ● Office of Experiential Education (OB 108A)
106 New Scotland Avenue, Albany, NY 12208-3492
Phone: (518) 694-7277 ● Fax: (518) 694-7302 ● Email: Diana.Foster@acphs.edu

ALBANY COLLEGE OF PHARMACY AND HEALTH SCIENCES

Meningococcal Meningitis Vaccination

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

HOME ADDRESS (NUMBER, STREET, CITY, STATE/PROVINCE/COUNTRY and ZIP/POSTAL CODE)

LAST 4 DIGITS OF SS#	MOBILE PHONE NUMBER	E-MAIL ADDRESS

New York State Public Health Law 2167 requires that all college and university students enrolled for at least six (6) semester hours, or the equivalent per semester, complete and return the following form. **Check one box and sign below.**

I have (or, for parents/guardians of students under the age of 18: My child has):

☐ Received the meningococcal meningitis immunization **within the past 5 years**. **Date received**: ____/____/____ (M D YY)

☐ Read, or have had explained to me, the information regarding meningococcal meningitis disease (below.) I will obtain immunization against meningococcal meningitis **within 30 days**, and provide the documentation to ACPHS.

☐ Read, or have had explained to me, the information regarding meningococcal meningitis disease (below.) I understand the risk of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease.

STUDENT, PARENT OR GUARDIAN SIGNATURE — DATE

Meningococcal Disease - Information for College students and Parents of Children at Residential Schools

New York State Department of Health, Bureau of Communicable Disease Control (Last Reviewed: August 2018)

Meningococcal disease is a severe bacterial infection of the bloodstream or inflammation of the lining around the brain and spinal cord (meninges).

Who gets meningococcal disease? Anyone can get meningococcal disease, but some people are at higher risk (teens and young adults). *For some adolescents, such as college students living in dormitories, there is an increased risk of the disease*. Other persons at increased risk include those: living with a damaged or no spleen, household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

How is meningococcal disease spread? It is spread by direct close contact with nose or throat discharges of an infected person. Close contact includes kissing, sharing beverages or eating utensils, or living together. Up to 1 in 10 people carry meningococcal bacteria in their nose or throat without getting sick. There have been several outbreaks of meningococcal disease at college campuses across the U.S.

What are the symptoms? High fever, headache, stiff neck, nausea and vomiting, eyes sensitive to light, and a red-purple rash are symptoms of meningococcal disease. The symptoms may appear 3 to 10 days after exposure, but usually within 4 days. Among people who develop meningococcal disease, 10 to 15 percent die, in spite of treatment with antibiotics. Among survivors, as many as 1 in 5 will have permanent disabilities, including brain damage, hearing loss, kidney damage or loss of arms or legs.

What is the treatment for meningococcal disease? Antibiotics can be used to treat people with meningococcal disease. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

What is the best way to prevent meningococcal disease? The single best way to prevent this disease is to be vaccinated. Various vaccines offer protection against the major strains of bacteria that cause the disease: *Meningococcal conjugate vaccines* (***MenACWY*: Menactra®, Menveo®),** *Serogroup B meningococcal vaccines* **(*MenB:* Bexsero® and Trumenba®).**

Is the vaccine safe? Are there adverse side effects to the vaccine? The vaccines available to prevent meningococcal meningitis are safe and effective. However, the vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days.

Who should get the meningococcal vaccine? The MenACWY vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States (U.S.). The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.

Who needs a booster dose of meningococcal vaccine? Adolescents who receive the first dose at age 13-15 years should receive a one-time booster dose, preferably at ages 16-18 years. Teens who receive their first dose of meningococcal conjugate vaccine at or after age 16 years do not need a booster dose, as long as they have no risk factors. All people who remain at highest risk for meningococcal infection should receive additional booster doses.

How do I get more information about meningococcal disease and vaccination? Contact your physician or your student health service. Additional information is also available on the websites of the NYS DOH (http://www.health.state.ny.us/) or the Centers for Disease Control & Prevention (http://www.cdc.gov/DiseasesConditions/).

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ALBANY COLLEGE OF PHARMACY AND HEALTH SCIENCES

Tuberculosis Screening Form

LAST NAME | FIRST NAME | MI | DATE OF BIRTH

HOME ADDRESS (NUMBER, STREET, CITY, STATE/PROVINCE/COUNTRY and ZIP/POSTAL CODE)

SOCIAL SECURITY NUMBER (Last 4#) | PHONE NUMBER | E-MAIL ADDRESS

To be completed by Incoming Students and their Healthcare Provider

(Healthcare Provider's Signature **REQUIRED** on the bottom of this form)

— *Tuberculosis Screening and Risk Assessment Questionnaire* —

1. Has the student ever had a **positive TB test**? ☐ Yes ☐ No ☐ Unknown

2. Has the student had recent **close contact** with someone with infectious TB disease? ☐ Yes ☐ No ☐ Unknown

3. Was the student born in, or have they traveled to/in, a **high-prevalence TB area**** within the last 5 years? (see list of high-prevalence countries below.)

☐ **YES**, Student is at **HIGH** Risk ☐ **NO**, Student is at low risk

4. Does the student fall under the category of "**high-risk**" due to:

a. HIV/AIDS, organ transplant recipient, history of illicit drug use

b. Being a resident, employee or volunteer in a high-risk setting, such as a correctional facility, nursing home or homeless shelter

c. A medical condition associated with increased risk of progression to TB, if infected (e.g. diabetes, silicosis, leukemia or lymphoma, chronic renal failure, chronic malabsorption syndrome, intestinal bypass or gastrectomy or other immunosuppressive disorder

☐ Yes ☐ No ☐ Unknown

If the answer is **NO** to **ALL** of the above questions, student is considered to be in a **Low-Risk** group—please PROCEED TO **PROVIDER SIGNATURE** AREA at the bottom of the form, confirming the risk group for this student. Nothing further needs to be done.

If the answer is **YES** to **ANY** of the above questions, student is considered to be in a **HIGH-RISK** group. **Section I MUST BE COMPLETED**

**** "High Prevalence"** areas are defined as areas with reported or estimated incidence of at least 20 cases per 100,000 population

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin,Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Colombia, Comoros, Congo, Cook Islands, Cote d'Ivoire, Croatia, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia (Federated States of), Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe

— *SECTION 1 - TUBERCULOSIS (TB) TESTING* —

Persons considered **HIGH-RISK** are required to have either Mantoux (PPD) tuberculin skin testing (TST) **OR** Interferon Gamma Release Assay (IGRA) within 6 months of their arrival on campus, **unless a previous positive test has been documented**. If the student's TB test is **positive** or if they have had a **previous positive** tuberculin skin test or IGRA, then a **chest x-ray within 6 months prior to student's arrival on campus is required** (proceed to item #3). *Please note:* a *history* of *BCG vaccination should **NOT** preclude testing of a member of a high risk group.*

1. Tuberculin Skin Test (TST) - PPD or Mantoux

TST result should be recorded as actual millimeters (mm) of induration; if no induration, write "0". The TST interpretation should be based on mm of induration and risk factors.

Date Given: _____/_____/_____ (M D YY) **Date Read**: _____/_____/_____ (M D YY) **Result**: _____mm of induration **Interpretation**: positive _____ negative _____

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: _____/_____/_____ (M D YY) **Method:** T-Spot_____ QFT-GIT _____ **Result:** positive _____ negative _____ indeterminate _____

3. Chest X-Ray: **Required within 6 months** prior to arrival on campus **if either** the TST or IGRA result is **positive** *or* there is a past history of a **positive** tuberculosis test.

Date of Chest X-Ray: _____/_____/_____ (M D YY) **Result:** normal _____ abnormal _____ Medication? _____

— *Provider Information and Signature REQUIRED* —

SIGNATURE OR STAMP OF HEALTHCARE PROVIDER | PRINTED NAME OF HEATHCARE PROVIDER

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