TO ENROLL AT STONY BROOK, COMPLETE BOTH PAGES OF THIS FORM AND MAIL OR FAX DIRECTLY TO:
Director, Student Health Service
Stony Brook University
Stony Brook, NY 11794-3191
Fax: (631) 632-6936 • TDD: (631) 632-6171

New York State Public Health Law and Stony Brook University Policy require that all students (Undergraduate, Transfer, Graduate, SPD students, Certificate Program students and Distance Learners) return a completed immunization form.

• Students born before 1957 are exempt from the Measles, Mumps and Rubella vaccine requirement.

Immunization information can be obtained from the following sources: Your private medical practitioner, high school health office, previous college health service (transfer students) or infant records held by parents that are signed by a physician. Have your physician’s office complete the enclosed Immunization/Health Form and return it to the Student Health Service, prior to Orientation. It is important that we receive the immunization information prior to your Orientation date to avoid registration problems. If you are unable to get a physical done prior to your Orientation, please have your practitioner fill out the immunization information section and return it to us.

PART I - REQUIRED IMMUNIZATION HISTORY

Please have your physician complete Section I and/or Section II and sign the back. DATE OF BIRTH: _________ / _________ / _________

SECTION I
List TWO dates of “MMR” (Measles, Mumps, Rubella) vaccine inoculation: .................................................... and ....................................
(Two doses of live vaccine administered on or after the first birthday after 1/68)
OR attach a copy of an immunization record signed by a practitioner.

SECTION II

A: MEASLES—complete ONE of the following:
1. TWO dates 30 days apart of Measles vaccination: .......................................................... and ....................................
   (Live vaccine administered on or after the first birthday after 1/68)
2. Approximate date of Measles infection (disease): ..............................................................
3. Date of blood test for Measles Immunity: ................................................................. Results Pos/Neg/Equiv

B: MUMPS—complete ONE of the following:
1. ONE date of Mumps vaccination: ................................................................................
   (Live vaccine administered on or after the first birthday after 1/69)
2. Approximate date of Mumps infection (disease): ..........................................................
3. Date of blood test for Mumps Immunity: ................................................................. Results Pos/Neg/Equiv

C: RUBELLA (German Measles)—complete ONE of the following:
1. ONE date of Rubella vaccination (live vaccine): ..........................................................
2. Date of blood test for Rubella Immunity: ................................................................. Results Pos/Neg/Equiv
PART III–PHYSICAL EXAMINATION

To avoid delay in treatment when medical problems arise, we request that the following statement be signed by a parent or legal guardian:

I hereby grant permission to the practitioners and nurses of the Stony Brook University Student Health Service to evaluate, treat or secure a referral to an outside agency for my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of a treatment plan or when needed for prevention of illness.

SIGNATURE OF PARENT OR GUARDIAN OR SPOUSE

DATE

Any allergy to:

- [ ] food
- [ ] medication
- [ ] other _________________________________

List surgeries or medications: _____________________________________________

PART II - HEALTH HISTORY

Please indicate if you or someone in your family has ever had any of the following:

<table>
<thead>
<tr>
<th>Illness</th>
<th>You</th>
<th>Parent</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach/Intestinal Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Trouble</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/Hay Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression/Anxiety /Mood Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High/Low Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infection</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Recurrent Headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury/Unconsciousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Trouble</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any allergy to: [ ] food [ ] medication [ ] other _________________________________

List surgeries or medications: _____________________________________________

PART III–PHYSICAL EXAMINATION

1 Height _____________________ 2 Weight __________________________
3 Blood Pressure __________ / __________ 4 Pulse __________
5 Vision Right 20/___________ Left 20/___________ Corr. 20/_________ to 20/_________

Describe any abnormalities in the space below:

Normal Abnormal

6  Head, Ears, Nose or Throat
7  Eyes (with Ophthalmoscope)
8  Hearing
9  Neck-Thyroid
10 Respiratory
11 Cardiovascular
12 Gastrointestinal

13 Hernia
14 Genitourinary
15 Musculoskeletal
16 Metabolic/Endocrine
17 Neuropsychiatric
18 Skin

Comment:

Other recommended Vaccines

19 HPV Vaccine
20 Hepatitis A
21 Hepatitis B
22 Varicella
23 Meningococcal Type
24 Tetanus (within 10 years)
25 Tetanus Diphtheria Acellular Pertussis (TDAP)
26 Polio
27 PPD Mantoux within 1 year mandatory (if test is positive, chest x-ray is required)
   Date__________ mm
28 BCG
   Date__________ NA__________
29 Chest x-ray (if positive PPD attach report)
   Date__________ Place____________________ Result____________________

I have reviewed all sections of this health form, including the required immunization information in Part 1 of this form. All information on this form is accurate and correct to the best of my knowledge.

SIGNATURE EXAMINING PRACTITIONER

NAME

ADDRESS

TELEPHONE NO. (INCLUDING AREA CODE)

DATE OF EXAMINATION

Practitioner Stamp

PERMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

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SIGNATURE OF PARENT OR GUARDIAN OR SPOUSE

DATE

RELATIONSHIP

TELEPHONE

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