To Students Admitted to the School of Nursing:
The Health Sciences schools’ student health policy requires that all students admitted to programs that involve education in clinical settings submit documentation of their health status and immunization history prior to the start of classes. NYS Public Health Law §2165 requires all students in post-secondary education to be immunized against measles, mumps and rubella.

In addition, NYS Public Health Law §2167 requires institutions, including colleges and universities, to distribute information to students about meningococcal disease and vaccination. Students must comply with this law by reading the required information about meningitis and completing the meningococcal vaccination response form available on your SOLAR account.

The Student Health Form has three (3) parts:

Part I – Health History; Part II – Physical Examination; Part III – Immunization History.

YOU MUST COMPLETE PART I BEFORE GOING TO A HEALTH PRACTITIONER FOR EXAMINATION.

SUBMIT THE COMPLETED FORM TO THE ABOVE ADDRESS AT LEAST TWO WEEKS BEFORE ATTENDING ORIENTATION.

The Registrar will block the registration of any student who is not in compliance with the policy/law. The Health Sciences schools will not authorize students to begin their clinical education unless their physical examination, required laboratory tests, and record of immunizations comply with the requirements listed below. Current records of health status need to be maintained by submitting the “Student Annual Physical Examination” form available by contacting the Office of Student Affairs at (631) 444-3200.

Requirements for registration and for clinical training include documentation of the following:

A. Physical examination completed by a licensed practitioner within two weeks of starting enrollment.

B. Required laboratory test results:
   1. **PPD Mantoux** prior to first enrollment; yearly thereafter if negative. If PPD is positive, a **copy of chest x-ray results** with place and date of examination is required. Students with positive PPD and/or positive chest x-ray will be referred to the Student Health Service for follow-up as appropriate.
   2. **Required Titers** (showing immunity): Measles, Mumps, Rubella, Varicella and Hepatitis (unless Hepatitis B vaccine declination statement is signed on page 4 of this form).
      2.a. All required titers must have copies of full laboratory reports attached to the Student Health Form.

C. Required immunizations:
   1. Tetanus or Tetanus/diphtheria (Td) toxoid within the past ten years
   2. Poliomyelitis vaccine

D. Strongly recommended immunizations:
   1. Hepatitis B vaccine
   2. Influenza vaccine
   3. Meningococcal vaccine
   4. Hepatitis A vaccine

When completed, mail the original and a copy directly to:

School of Nursing
Office of Student Affairs
Stony Brook University
Stony Brook, NY 11794-8240
Tel: (631) 444-3200

Health Form – Nursing
PART I—HEALTH HISTORY

Student: Please complete all sections on pages 2 and 3 before going to your health practitioner for examination.

Name (PRINT) ___________________________ Date of Birth ___________________________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Other

Home Address _____________________________________________________________

NUMBER AND STREET ______________________________________________________

CITY/TOWN ________________________________________________________________

STATE ZIP CODE __________________________________________________________

Home Telephone __________________________________________________________

Cell Phone ______________________________________________________________

Local/Campus Address (if known) _____________________________________________

NUMBER AND STREET ______________________________________________________

CITY/TOWN ________________________________________________________________

STATE ZIP CODE __________________________________________________________

Telephone ______________________________________________________________

Name and address of parent, guardian, or spouse (if different from above) __________

Address _________________________________________________________________

NUMBER AND STREET ______________________________________________________

CITY/TOWN ________________________________________________________________

STATE ZIP CODE __________________________________________________________

Business Telephone _______________________________________________________

Physician _________________________________________________________________

NAME _________________________________________________________________

Telephone ______________________________________________________________

Address _________________________________________________________________

NUMBER AND STREET ______________________________________________________

CITY/TOWN ________________________________________________________________

STATE ZIP CODE __________________________________________________________

Telephone ______________________________________________________________

Where have you lived most of your life? (check one)

☐ United States ☐ Canada ☐ Mexico ☐ Central America ☐ South America ☐ Caribbean ☐ Europe

☐ Africa ☐ Middle East ☐ India ☐ Pakistan ☐ Far East ☐ Australia/New Zealand ☐ Other

RELEASE OF INFORMATION AUTHORIZATION

I give authorization for the release of the Student Health History and Examination Form and Student Annual Physical Examination forms to the Office of Student Affairs, the Department of Clinical Placement, the Dean of the School of Nursing, the Student Health Service, the Stony Brook University Hospital Employee Health Service Department, and other hospitals and clinical affiliates where I might be engaged in clinical instruction as part of my academic training at the Health Sciences school of Stony Brook University.

STUDENT’S SIGNATURE ___________________________ DATE ___________________________

PERMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

When serious medical problems arise, every effort will be made to reach parents, guardians, or spouse. On occasion, we are unable to make this contact. To avoid delay in treatment, we request that the following statement be signed by a parent, legal guardian, or spouse:

I hereby grant permission to treat and/or hospitalize my son/daughter/spouse/ward in case of illness/injury.

SIGNATURE OF PARENT OR GUARDIAN OR SPOUSE/RELATIONSHIP ___________________________ DATE ___________________________
## B. PERSONAL HEALTH HISTORY—PLEASE ANSWER ALL QUESTIONS

Comment on all positive responses in space provided below. **Y = YES, N = NO**

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Scarlet Fever Disease</td>
<td>37</td>
<td>Allergies (specify): Penicillin</td>
<td>55</td>
<td>Recurrent Diarrhea</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Measles Disease</td>
<td>38</td>
<td>Allergies: Other Drugs</td>
<td>56</td>
<td>Surgery (list with dates in space provided)</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>German Measles Disease</td>
<td>39</td>
<td>Hay Fever, Asthma</td>
<td>57</td>
<td>Head Injury with Unconsciousness</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Mumps Disease</td>
<td>40</td>
<td>Chronic Cough</td>
<td>58</td>
<td>Rupture, Hernia</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Chicken Pox Disease</td>
<td>41</td>
<td>Rheumatic Fever</td>
<td>59</td>
<td>Recent Weight Gain</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Mononucleosis</td>
<td>42</td>
<td>Heart Murmur</td>
<td>60</td>
<td>Recent Weight Loss</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Malaria</td>
<td>43</td>
<td>Pain/Pressure in Chest</td>
<td>61</td>
<td>Tuberculosis or Positive TB Test</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Eye Trouble</td>
<td>44</td>
<td>Palpitation (Heart)</td>
<td>62</td>
<td>Venereal Disease</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Ear, Nose, Throat Trouble</td>
<td>45</td>
<td>Shortness of Breath</td>
<td>63</td>
<td>Albumin in Urine</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Sinusitis</td>
<td>46</td>
<td>High Blood Pressure</td>
<td>64</td>
<td>Sugar in Urine</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Hearing Difficulty</td>
<td>47</td>
<td>Dizziness or Fainting</td>
<td>65</td>
<td>Frequent Urination</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Speech Difficulty</td>
<td>48</td>
<td>Convulsions or Epilepsy</td>
<td>66</td>
<td>Urinary Tract Infections</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Diabetes</td>
<td>49</td>
<td>Weakness, Paralysis</td>
<td>67</td>
<td>Painful Urination</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Insomnia</td>
<td>50</td>
<td>Arthritis, Rheumatism, Joint Trouble</td>
<td>FEMALES ONLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Frequent Anxiety</td>
<td>51</td>
<td>Back Problems</td>
<td>68</td>
<td>Irregular Periods</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Frequent Depression</td>
<td>52</td>
<td>Stomach or Intestinal Trouble</td>
<td>69</td>
<td>Severe Cramps</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Worry or Nervousness</td>
<td>53</td>
<td>Gallbladder Trouble</td>
<td>70</td>
<td>Excessive Flow</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Recurrent Headaches</td>
<td>54</td>
<td>Jaundice or Hepatitis</td>
<td>71</td>
<td>Number of Pregnancies</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Recurrent Colds</td>
<td></td>
<td></td>
<td>72</td>
<td>Number of Live Births</td>
<td></td>
</tr>
</tbody>
</table>

---

### C. MEDICATION

Are you currently taking any medication?  
☐ Yes  ☐ No  
Please list (including birth control pills):

---

### COMMENTS:

---

Practitioner Signature  
(Acknowledging Review of Health History)

---
**Hepatitis B Vaccine Declination**

I understand that I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring HBV, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series by Student Health Service.

_________________________________________________________________________________
Student's Signature  Date

---

**PART II–PHYSICAL EXAMINATION**

To the Examining Practitioner:

Please review the student's history and complete applicable parts of the examination form. **THIS STUDENT HAS BEEN ADMITTED TO THE UNIVERSITY.** The information will not be used to influence status at the University; it will be used only as a background for providing health care, if necessary, while enrolled as a student. This information is confidential. It will not be released to anyone without the student's knowledge and consent. However, after the student signs consent, this form can be sent to Stony Brook University Hospital as described in “Release of Information Authorization” on page 2 of this form.

1 Height ________________  2 Weight ________________  3 Blood Pressure ___________ / ___________  4 Pulse ________________
5 Vision Right 20/ ___________ Corr. 20/ ___________  6 Head, Ears, Nose, or Throat

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Eyes (with Ophthalmoscope)</td>
<td>13 Hernia</td>
</tr>
<tr>
<td>8 Hearing</td>
<td>14 Genitourinary</td>
</tr>
<tr>
<td>9 Neck-Thyroid</td>
<td>15 Musculoskeletal</td>
</tr>
<tr>
<td>10 Respiratory</td>
<td>16 Metabolic/Endocrine</td>
</tr>
<tr>
<td>11 Cardiovascular</td>
<td>17 Neuropsychiatric</td>
</tr>
<tr>
<td>12 Gastrointestinal</td>
<td>18 Skin</td>
</tr>
</tbody>
</table>

Describe any abnormalities of the following systems in the space below.

---

**PART III–IMMUNIZATION HISTORY**

**IMMUNIZATIONS REQUIRED**

<table>
<thead>
<tr>
<th>Dates of Injections</th>
<th>IMMUNIZATIONS REQUIRED</th>
</tr>
</thead>
</table>

**TITERS/LAB REPORTS REQUIRED** (attach copies)  
LAB REPORT MUST INCLUDE INDEX/VALUES  

<table>
<thead>
<tr>
<th>Device</th>
<th>Date</th>
<th>Pos</th>
<th>Neg</th>
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</thead>
</table>

**IMMUNIZATIONS STRONGLY RECOMMENDED**

<table>
<thead>
<tr>
<th>Dates of Injections</th>
<th>IMMUNIZATIONS STRONGLY RECOMMENDED</th>
</tr>
</thead>
</table>

---

**Hepatitis B Vaccine Declination**

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Student's Signature ___________________________ Date ___________________________

Examining Practitioner Signature ___________________________ Date of Examination ___________________________

Name ___________________________ Telephone No. (include area code) (______) ___________________________

Address ___________________________ Zip ___________________________