

# Health Form



STATE UNIVERSITY OF NEW YORK

**When Completed, Mail Directly to:**

Director, Student Health Service  
Stony Brook University  
Stony Brook, New York 11794-3191

**Student Health Service**

Tel: (631) 632-6740  
TDD: (631) 632-6171  
Fax: (631) 632-6936

Name \_\_\_\_\_ ID# \_\_\_\_\_  
(Print) Last First Middle

Home Address \_\_\_\_\_ ( ) \_\_\_\_\_  
Number and Street City/Town State Zip Code Home Telephone

E-mail Address \_\_\_\_\_ ( ) \_\_\_\_\_  
Cell Phone

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ ( ) \_\_\_\_\_  
Phone

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.**

<b>PART I—REQUIRED IMMUNIZATION INFORMATION</b>	<b>DATE OF BIRTH:</b> _____ / _____ / _____ <small>month day year</small>
<i>Please have your physician complete either Section I and/or Section II and sign the back.</i>	
<b>SECTION I</b> List <b>TWO</b> dates of “MMR” (Measles, Mumps, Rubella) vaccine inoculation: _____ and _____ <b>(Two doses of live vaccine administered on or after the first birthday after 1/68)</b> <b>OR attach a copy of an immunization record signed by a practitioner.</b>	
<b>SECTION II</b> <b>A: MEASLES—complete ONE of the following:</b> 1. <b>TWO</b> dates 30 days apart of Measles vaccination: _____ and _____ <b>(Live vaccine administered on or after the first birthday after 1/68)</b> 2. Approximate date of Measles infection (disease): _____ 3. Date of blood test for Measles Immunity: _____ Results _____ <small>Pos/Neg/Equiv</small>	
<b>B: MUMPS—complete ONE of the following:</b> 1. <b>ONE</b> date of Mumps vaccination: _____ <b>(Live vaccine administered on or after the first birthday after 1/69)</b> 2. Approximate date of Mumps infection (disease): _____ 3. Date of blood test for Mumps Immunity: _____ Results _____ <small>Pos/Neg/Equiv</small>	
<b>C: RUBELLA (German Measles)—complete ONE of the following:</b> 1. <b>ONE</b> date of Rubella vaccination (live vaccine): _____ 2. Date of blood test for Rubella Immunity: _____ Results _____ <small>Pos/Neg/Equiv</small>	

## Part II-Health History

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **ID#** \_\_\_\_\_

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

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

Illness	You	Parent	GP
Seizures/Convulsions			
Chronic Cough			
Alcohol/Drug Abuse			
Heart Murmur/Disease/Clotting Disorder			
Joint Disease/Injury			
Jaundice/Hepatitis			
Tuberculosis			
Eating Disorder			
Recent Weight Loss/Gain			
Dizziness/Fainting			
Weakness/Paralysis			
Kidney Problems/Urinary Problems			
Surgery (list below)			
Current Medications (list below)			

Any allergy to:  food  medication  other \_\_\_\_\_ List surgeries or medications: \_\_\_\_\_

## Part III-Physical Examination

1 Height \_\_\_\_\_ 2 Weight \_\_\_\_\_ 5 Vision Right 20/ \_\_\_\_\_ Corr. 20/  
 3 Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ 4 Pulse \_\_\_\_\_ Left 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		

	Normal	Abnormal
13 Hernia		
14 Genitourinary		
15 Musculoskeletal		
16 Metabolic/Endocrine		
17 Neuropsychiatric		
18 Skin		
Comment:		

OTHER RECOMMENDED VACCINES	Dates
19 HPV VACCINE	
20 HEPATITIS A	
21 HEPATITIS B	
22 VARICELLA	
23 MENINGOCOCCAL TYPE	
24 TETANUS (within 10 years)	
25 TETANUS DIPHTHERIA ACCELLULAR 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.

**Signed** \_\_\_\_\_  
*Examining Practitioner*

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. (including area code) (\_\_\_\_\_) \_\_\_\_\_

Date of Examination \_\_\_\_\_

### Practitioner Stamp

### PERMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

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 Story 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*

\_\_\_\_\_  
*Relationship*

(\_\_\_\_\_) \_\_\_\_\_  
*Telephone*