

Health Form, Part I

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



STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE NAME	STONY BROOK ID#	
ADDRESS	STREET/APT.#	CITY	STATE/PROVINCE	ZIP CODE COUNTRY (IF NOT U.S.)
HOME PHONE	CELL PHONE	E-MAIL		
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.

PART I - REQUIRED IMMUNIZATION HISTORY

Please have your physician complete either Section I and/or Section II and sign the back. DATE OF BIRTH: _____ / _____ / _____
MONTH DAY YEAR

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

Health Form, Part II and III



STUDENT LAST NAME (PLEASE PRINT) _____

FIRST NAME _____

STONY BROOK ID# _____

PART II - HEALTH HISTORY

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/Hayfever			
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 _____

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		

	Normal	Abnormal
13 Hernia		
14 Genito-urinary		
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 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

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 _____

RELATIONSHIP _____

TELEPHONE _____