

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

Important Health Requirements

THINGS YOU NEED TO DO BEFORE ORIENTATION

You must complete and return the three forms in this booklet before the required date or you will be unable to remain registered for your classes.

1. Complete the **Immunization Form**, which includes documenting that you have the required immunity for measles, mumps, and rubella (MMR), and return it to the Student Health Service two weeks *before* your Orientation date (this form must be signed by your physician). If you're not 18 years old yet, then you must also have your parent or guardian fill out the Under 18 Consent for Emergency/Medical Treatment section and return it to the Student Health Service.
2. Complete the **Meningitis Response Form** two weeks *before* your Orientation date. If you are over 18 years of age, you can do this on SOLAR at www.stonybrook.edu/solarsystem. If you are under 18, you must have a parent or guardian complete the form at <http://studentaffairs.stonybrook.edu/shs/docs/Meningitis.pdf> or use the form in this booklet. Please make sure to read the information regarding meningitis on the form and on the Web site.
3. Send in a completed **Health Form** (Health History and Physical) *before* the first day of classes.

All forms must be returned to:

Student Health Service
1 Stadium Road
Stony Brook University
Stony Brook, NY 11794-3191
Telephone: (631) 632-6740
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Eligibility to remain a registered student rests with YOU.

You MUST keep a copy of all forms that you submit to the Student Health Service for your records. It is recommended that you bring a copy of all submitted forms to your Orientation.

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Immunization Form

STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE NAME	STONY BROOK ID#	
HOME ADDRESS	STREET/APT.#	CITY/TOWN	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. Have your physician's office complete this form and return it to the Student Health Service **TWO WEEKS PRIOR TO YOUR ORIENTATION DATE**, so your form can be processed early to avoid registration/de-registration problems. If you are unable to get your physician to fill this out, immunization information can be obtained from other sources: Sources such as your high school health office, previous college health service (transfer students), or infant immunization records held by parents that are signed by a physician will be accepted and need to be attached to this form.

The Health Form (Health History and Physical Form) must be completed by your physician and returned to the Student Health Service before the first day of classes.

Please have your physician complete Section I and/or Section II and sign below.	DATE OF BIRTH: _____ / _____ / _____ <small style="text-align: center;">MONTH DAY YEAR</small>
SECTION I List TWO dates of "MMR" (Measles, Mumps, Rubella) vaccine inoculation and <i>(Two doses of live vaccine administered on or after the first birthday after 1/68)</i> 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 <i>(Live vaccine administered on or after the first birthday after 1/68)</i> 2. Approximate date of Measles infection (disease) 3. Date of blood test for Measles Immunity Results _____ <div style="text-align: right;">Pos/Neg/Equiv</div>	
B: MUMPS—complete ONE of the following: 1. ONE date of Mumps vaccination <i>(Live vaccine administered on or after the first birthday after 1/69)</i> 2. Approximate date of Mumps infection (disease) 3. Date of blood test for Mumps Immunity Results _____ <div style="text-align: right;">Pos/Neg/Equiv</div>	
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 _____ <div style="text-align: right;">Pos/Neg/Equiv</div>	
PHYSICIAN'S SIGNATURE / STAMP _____	DATE _____

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	RELATIONSHIP	DATE
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Meningitis Response Form

STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE NAME	STONY BROOK ID#	
HOME ADDRESS	STREET/APT.#	CITY/TOWN	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 must verify by their signature that they have received information about meningococcal disease and have made an informed decision about whether or not to receive immunization against meningococcal disease. Student must demonstrate compliance with this requirement within 30 days after the first day of classes. The Registrar will block and de-register students who fail to comply with this health requirement.

Student may comply with this law by reading the required information regarding meningitis at this Web site: <http://studentaffairs.stonybrook.edu/shs/docs/Meningitis.pdf> and then completing this form.

If you are 18 years of age or older or you do not wish to use this form, this requirement can be met by logging on to your SOLAR account and reading the information and submitting your response electronically.

Your response to this form must be received two weeks before your Orientation date. It is important that we receive the immunization information before that date so your form can be processed early to avoid registration/de-registration problems.

Check one box and sign below.

I have (For students under the age of 18: My child has):

had the meningococcal meningitis immunization (Menomune™ or Menactra™) within the past 10 years.
Date received: _____

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

SIGNATURE (PARENT/GUARDIAN IF STUDENT IS A MINOR)

RELATIONSHIP

DATE

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Health Form

STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE NAME	STONY BROOK ID#	
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HOME PHONE	CELL PHONE	E-MAIL		
EMERGENCY CONTACT	RELATIONSHIP	PHONE		

This Health Form must be completed by your practitioner and must be received by the Student Health Service before the first day of classes. If you are under the age of 18 the consent for treatment on this form must be signed by your parent or guardian.

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SIGNATURE OF PARENT OR GUARDIAN OR SPOUSE	RELATIONSHIP	PHONE	DATE
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HEALTH HISTORY

Current Medications:	Chronic Medical Conditions:
Allergies (including drug and other):	
Psychological Conditions:	Surgical Procedures:

PHYSICAL EXAMINATION

Height _____ Weight _____ Vision Right 20/_____ Corr. Right 20/_____
 Blood Pressure _____ / _____ Pulse _____ Left 20/_____ Corr. left 20/_____

	Normal	Abnormal	Recommended Vaccines	Dates
Head, Eyes, Ears, Nose, Throat			HPV VACCINE	#1 #2 #3
Neck-Thyroid			HEPATITIS A	#1 #2
Respiratory			HEPATITIS B	#1 #2 #3
Cardiovascular			VARICELLA	#1 #2 or Date Had Disease
Gastrointestinal			MENINGOCOCCAL TYPE	
Genito-urinary/Hernia			TETANUS (within 10 years)	
Musculoskeletal			TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (TDAP)	
Neuropsychiatric			POLIO	
Skin			PPD Mantoux (if test is positive, chest X-ray is required)	Date _____ mm
Comments:			BCG	Date _____ NA _____
			Chest X-ray (if positive PPD, please attach report) Date _____ Place _____ Result _____ If chest X-ray was positive was/is patient on INH Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I have reviewed all sections of this Health Form including the immunization information. I acknowledge, to the best of my knowledge, that the information on this form is accurate and correct.

SIGNATURE EXAMINING PRACTITIONER <input type="checkbox"/> MD / <input type="checkbox"/> PA / <input type="checkbox"/> NP	DATE	PRINT NAME
ADDRESS	PRACTITIONER STAMP:	
TELEPHONE NO. (INCLUDING AREA CODE)		

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