

# Young Scholars Program Application for Spring 2012

PLEASE PRINT LEGIBLY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Male  Female

Date of Birth: \_\_\_\_\_  
month/day/year

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Email (required) \_\_\_\_\_

U.S. Citizen  Permanent Resident If not a US citizen or permanent resident, indicate your visa type: \_\_\_\_\_

Possible College Major: \_\_\_\_\_ If you wish to identify yourself as a disabled student, check here

Indicate the course(s) in which you wish to enroll (specify both course numbers *and* lecture numbers)

**Note: If you're applying for a course with an AP prerequisite, you must include a copy of your AP score(s) with this application.**

| 1st Choice |          | 2nd Choice |          | 3rd Choice |          |
|------------|----------|------------|----------|------------|----------|
| Course:    | Lecture# | Course:    | Lecture# | Course:    | Lecture# |
|            |          |            |          |            |          |

How did you learn about the Young Scholars Program? \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Have you previously taken a course at Stony Brook?  No  Yes: please provide your Stony Brook ID#: \_\_\_\_\_

**Note: A minimum cumulative Stony Brook GPA of 3.0 is required for continued enrollment in the Young Scholars Program.**

| To be completed by secondary school guidance counselor/principal as indication of support for student's application |                            |                             |
|---|----------------------------|-----------------------------|
| Name of Secondary School  |                            | Expected Date of Graduation |
| SAT Scores (if available)<br>Math:            Critical Reading:   | PSAT Scores (if available) | High School GPA:            |
| Secondary School Signature of Approval  |                            | Position                    |
| Print Name  |                            | Date                        |

## APPLICATION DEADLINE: FRIDAY, DECEMBER 23, 2012

This application should be detached and submitted with an official copy of the applicant's secondary school transcript, and a check made payable to Stony Brook University for the \$250 per course program fee. (This fee is non-refundable once the student is admitted.)

**Mail Your Application, Transcript, and \$250 Check To:**

**Lyle S. Wind/Young Scholars Program Coordinator  
Undergraduate Admissions  
Stony Brook University  
Stony Brook, NY 11794-1901**

**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

## 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. 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.

**This form must be returned at the same time you submit your Young Scholars Program application. 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

**PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS BEFORE YOU SEND IT IN.**

**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

# 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 return a completed immunization form. Have your physician's office complete this form and return it to the Student Health Service **AT THE SAME TIME YOU SUBMIT YOUR YOUNG SCHOLARS PROGRAM APPLICATION**, 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.

|  |  |
|--|--|
| <b>Please have your physician complete Section I and/or Section II and sign below.</b>   | <b>DATE OF BIRTH:</b> _____ / _____ / _____<br><small style="text-align: center;">MONTH DAY YEAR</small> |
| <b>SECTION I</b><br>List <b>TWO</b> dates of "MMR" (Measles, Mumps, Rubella) vaccine inoculation ..... _____ and _____<br><i>(Two doses of live vaccine administered on or after the first birthday after 1/68)</i><br><b>OR attach a copy of an immunization record signed by a practitioner.</b>   |  |
| <b>SECTION II</b><br><b>A: MEASLES—complete ONE of the following:</b><br>1. <b>TWO</b> dates 30 days apart of Measles vaccination ..... _____ and _____<br><i>(Live vaccine administered on or after the first birthday after 1/68)</i><br>2. Approximate date of Measles infection (disease) ..... _____<br>3. Date of blood test for Measles Immunity ..... _____ Results _____<br><div style="text-align: right;">Pos/Neg/Equiv</div> |  |
| <b>B: MUMPS—complete ONE of the following:</b><br>1. <b>ONE</b> date of Mumps vaccination ..... _____<br><i>(Live vaccine administered on or after the first birthday after 1/69)</i><br>2. Approximate date of Mumps infection (disease) ..... _____<br>3. Date of blood test for Mumps Immunity ..... _____ Results _____<br><div style="text-align: right;">Pos/Neg/Equiv</div>   |  |
| <b>C: RUBELLA (German Measles)—complete ONE of the following:</b><br>1. <b>ONE</b> date of Rubella vaccination (live vaccine) ..... _____<br>2. Date of blood test for Rubella Immunity ..... _____ Results _____<br><div style="text-align: right;">Pos/Neg/Equiv</div>   |  |
| _____<br><small>PHYSICIAN'S SIGNATURE / STAMP</small>  | _____<br><small>DATE</small>   |

**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 |
|---|--------------|------|

**PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS BEFORE YOU SEND IT IN.**