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](http://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](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.

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All forms must be returned to:

Student Health Service  
1 Stadium Road  
Stony Brook University  
Stony Brook, NY 11794-3191  
Telephone: (631) 632-6740  
Fax: (631) 632-6936

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.
Immunization Form

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: / / __________

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 and 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 and 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

PHYSICIAN’S SIGNATURE / 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

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

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

Health 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

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.

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  PHONE  DATE

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  _______________

Recommended Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV VACCINE</td>
<td></td>
<td></td>
<td>#3</td>
</tr>
<tr>
<td>HEPATITIS A</td>
<td>#1</td>
<td></td>
<td>#2</td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>#1</td>
<td>#2</td>
<td>#3</td>
</tr>
<tr>
<td>VARICELLA</td>
<td>#1</td>
<td>#2</td>
<td>or Date Had Disease</td>
</tr>
</tbody>
</table>

MENINGOCOCCAL TYPE

TETANUS (within 10 years)

TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (Tdap)

POLIO

PPD Mantoux (if test is positive, chest X-ray is required)  Date_____________  mm

BCG  Date_____________  NA

Chest X-ray (if positive PPD, please attach report)

Date_____________  Place________________

If chest X-ray was positive was/is patient on INH Treatment?  Yes  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  [MD / PA / NP]  DATE  PRINT NAME

ADDRESS

TELEPHONE NO. (INCLUDING AREA CODE)

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