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.

**Immunization Form**

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 ____________

   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

**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.