When Completed, Mail Directly to:
Director, Sports Medicine
Stony Brook University
Indoor Sports Complex
100 Nicolls Rd. Stony Brook, New York 11794-3500

Stony Brook University

STONY BROOK SPORTS MEDICINE
Tel: (631) 632-6448
Fax: (631) 632-3231

Health Form - Intercollegiate Athletics

STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE NAME	STONY BROOK ID #	DATE OF BIRTH	SPORT

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 prior to your scheduled Athletic Physical. If you are under the age of 18 the consent for treatment on this form must be signed by your parent or guardian.
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 _____

MEDICAL SCREENING

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			
SEIZURES / CONVULSIONS			

ILLNESS	YOU	PARENT	GP
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			

PHYSICAL EXAM

Height _____ Weight _____ Vision Right 20/_____ Corr. Right 20/_____

Blood Pressure _____ / _____ Pulse _____ Left 20/_____ Corr. Left 20/_____

Describe any abnormalities of the following systems in the space below.

	NORMAL	ABNORMAL
HEAD, EYES, NOSE, THROAT		
EYES (WITH OPHTHALMOSCOPE)		
HEARING		
NECK-THYROID		
RESPIRATORY		
CARDIOVASCULAR		
GASTROINTESTINAL		

	NORMAL	ABNORMAL
HERNIA		
GENITOURINARY		
MUSCULOSKELETAL		
METABOLIC/ENDOCRINE		
NEUROPSYCHIATRIC		
SKIN		

REQUIRED TESTS	DATES OF INJECTION
SICKLE CELL SOLUBILITY TEST (Attach a copy of result)	RESULT:
PPD—MANTOUX / IGRA (If test is positive, a chest x-ray is required) RESULT _____ MM _____DATE_____	CHEST X-RAY (**ONLY IF PPD IS POSITIVE**- PLEASE ATTACH REPORT) DATE_____ PLACE_____
REQUIRED VACCINE	
MMR	#1 #2
Tdap / TETANUS (Tetanus within 10 years)	#1

RECOMMENDED VACCINES	DATES		
MENINGOCOCCAL VACCINE (Booster after age 16)	TYPE ACYW135 #1 _____ #2 _____ TYPE B #1 _____ #2 _____		
VARICELLA VACCINE	#1 _____ #2 _____ HAD DISEASE DATE: _____		
HEPATITIS A VACCINE	#1	#2	
HEPATITIS B VACCINE	#1	#2	#3
HPV VACCINE	#1	#2	#3

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. I have examined the above patient and have found him/her physically fit to compete in intercollegiate sports.

SIGNATURE EXAMINING PRACTITIONER ☐ MD / ☐ PA / ☐ NP DATE PRINT NAME

ADDRESS PRACTITIONER STAMP:

TELEPHONE NO. (INCLUDING AREA CODE)