Completed Form needs to be uploaded at our Patient Portal @ https://stonybrook.medicatconnect.com

Stony Brook University

STUDENT HEALTH SERVICE
Tel: (631) 632-6740
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

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:

Allergies (including drug and other):

Chronic Medical Conditions:

Surgical Procedures:

PHYSICAL EXAMINATION

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

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

SYSTEM	Normal	Abnormal	SYSTEM	Normal	Abnormal
Head			Respiratory		
Eyes			Gastrointestinal		
Ears			Genito-urinary/Hernia		
Nose			Musculoskeletal		
Throat / Neck			Neuropsychiatric		
Cardiovascular			Skin		
Comments:					

Tuberculosis Screening	
QUANTIFERON GOLD (Attach result)	Result _____ Date_____
PPD Mantoux (if test is positive, Chest X-ray is required)	Date_____ _____mm
History of BCG Vaccination	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? ☐Yes ☐No	

I have reviewed all sections of this Health Form. 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 PRACTITIONER STAMP:

TELEPHONE NO. (INCLUDING AREA CODE)

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