Completed Forms 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

Immunization Form

STUDENT LAST NAME (PLEASE PRINT) FIRST NAME MIDDLE NAME SBID#

HOME ADDRESS STREET/APT.# CITY/TOWN STATE/PROVINCE ZIP CODE

HOME PHONE CELL PHONE

New York State Public Health Law and Stony Brook University Policy require that ALL students enrolled for **any on campus courses** return a completed immunization form. Student Health Service must receive your immunization data PRIOR TO YOUR ORIENTATION/ENROLLMENT DATE**, *In lieu of this form, immunization information can be obtained from other sources*: 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. A healthcare provider signature and stamp is required or the form will not be processed.**

You can upload the completed form through our patient portal @ https://stonybrook.medicatconnect.com

REQUIRED IMMUNIZATIONS (to be completed by a healthcare provider)

MMR (Measles, Mumps, Rubella)
☐ Dose 1 (Not immunized prior to first birthday and after 1971) Date ___/___/____ **DATE OF BIRTH**_____/____/____
☐ Dose 2 (Immunized as above and at least 28 days after the first dose) Date ___/___/____

Or

Measles—Two doses at least 28 days apart, given no more than four days prior to the first birthday and after 1967
☐ Dose 1 Immunized on or after January 1, 1968 Date ___/___/____
☐ Dose 2 Immunized as above and at least 28 days after the first dose) Date ___/___/____
Mumps - one dose after January 1, 1968 Date ___/___/____
Rubella—one dose after January 1, 1968 Date ___/___/____

Or

Serologic evidence of immunity for each disease– Laboratory report verifying immunity (IgG) to measles, mumps and rubella are required (titers).
LAB REPORTS MUST BE ATTACHED.
Note: If student is a Medical, Dental, Nursing, or clinical Health Technology and Management student, serologic evidence of immunity (titers) to measles, mumps, rubella, varicella, and hepatitis B will be required for clinical rotations. Please check with your school to see if there are other required immunizations

Meningitis Vaccination Response Form
Students may comply with New York State Public Health Law 2167 regarding meningitis by reading the required information regarding meningitis at this Web site: www.health.ny.gov/publications/2168.pdf and then completing this form.
Check one box and sign below. I have (For students under the age of 18: My child has):
☐ had the meningococcal meningitis immunization within the past 5 years. Official documentation of vaccination is submitted on this form.
☐ 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 of student (if 18 or older) / parent or guardian (if student is a minor) Date

RECOMMENDED IMMUNIZATIONS

Meningococcal ACYW135	Dose #1 ____/____/____	Dose #2 ____/____/____	
Meningococcal Type B	Dose #1 ____/____/____	Dose #2 ____/____/____	
TDaP	Date ____/____/____ **Or**		
Tetanus Toxoid (within 10 years)	Date ____/____/____		
Varicella (Chicken Pox)	Dose #1 ____/____/____	Dose #2 ____/____/____	
Hepatitis B series	Dose #1 ____/____/____	Dose #2 ____/____/____	Dose #3 ____/____/____
Hepatitis A (if traveling abroad)	Dose #1 ____/____/____	Dose #2 ____/____/____	
HPV Vaccine	Dose #1 ____/____/____	Dose #2 ____/____/____	Dose #3 ____/____/____
COVID-19 Vaccine:_____ Name of Vaccine (Print Name)	Dose #1 ____/____/____	Dose #2 (If applicable) ____/____/____	

Healthcare Provider Signature: (MD/NP/PA):_____**Date**:_____ **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 RELATIONSHIP PHONE DATE

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