Health Form

STONY BROOK
STATE UNIVERSITY OF NEW YORK

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

Name_____ ID# _____
(Print) Last First Middle

Home Address _____ (____)_____
Number and Street City/Town State Zip Code Home Telephone

E-mail Address _____ (____)_____
Cell Phone

Emergency Contact_____Relationship_____ (____)_____
Phone

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.

- **Students born before 1957 are exempt from the Measles, Mumps, and Rubella vaccine requirement.**

Immunization information can be obtained from the following sources: Your private medical practitioner, high school health office, previous college health service (transfer students), or infant records held by parents that are signed by a physician. Have your physician's office complete the enclosed Immunization/Health Form and return it to the Student Health Service, ***prior to Orientation. It is important that we receive the immunization information prior to your Orientation date. If you are unable to get a physical done prior to your Orientation, please have your practitioner fill out the immunization information and return to us.***

PART I–REQUIRED IMMUNIZATION INFORMATION

DATE OF BIRTH: _____ /_____ /_____
month day year

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

Part II–Health History

Last Name_____ **First Name**_____ **ID#**_____

Please indicate if you or someone in your family has ever had any of the following:

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			

Illness	You	Parent	GP
Seizures/Convulsions			
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 (list below)			

Any allergy to: ❑ food ❑ medication ❑ other _____ List surgeries or medications: _____

Part III–Physical Examination

1 Height _____ 2 Weight _____ 5 Vision Right 20/ Corr. 20/

3 Blood Pressure _____ / _____ 4 Pulse _____ Left 20/ to 20/

Describe any abnormalities in the space below:

	Normal	Abnormal
6 Head, Ears, Nose, or Throat		
7 Eyes (with Ophthalmoscope)		
8 Hearing		
9 Neck-Thyroid		
10 Respiratory		
11 Cardiovascular		
12 Gastrointestinal		

	Normal	Abnormal
13 Hernia		
14 Genito-urinary		
15 Musculoskeletal		
16 Metabolic/Endocrine		
17 Neuropsychiatric		
18 Skin		
Comment:		

OTHER RECOMMENDED VACCINES	Dates
19 HPV VACCINE	
20 HEPATITIS A	
21 HEPATITIS B	
22 VARICELLA	
23 MENINGOCOCCAL TYPE	
24 TETANUS (within 10 years)	
25 TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (TDAP)	
26 POLIO	
27 PPD Mantoux within 1 year mandatory (if test is positive, chest X-ray is required)	Date_____ _____mm
28 BCG	Date_____ NA_____
29 Chest X-ray (if positive PPD attach report) Date_____ Place_____ Result_____	

I have reviewed all sections of this health form including the required immunization information in Part 1 of this form. I acknowledge, to the best of my knowledge, that the information on this form is accurate and correct.

Signed _____

Examining Practitioner

Name _____

Address _____

_____

Telephone No. (including area code) (_____) _____

Date of Examination _____

Practitioner 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 *Date*

_____ (_____)_____

Relationship *Telephone*