Health Form, Part I

TO ENROLL AT STONY BROOK, COMPLETE BOTH PAGES OF THIS FORM AND MAIL OR FAX DIRECTLY TO:

Director, Student Health Service
Stony Brook University
Stony Brook, NY 11794-3191
Fax: (631) 632-6936 • TDD: (631) 632-6171

Stony Brook University

STUDENT LAST NAME (PLEASE PRINT) | FIRST NAME | MIDDLE NAME | STONY BROOK ID#

ADDRESS | STREET/APT.# | CITY | STATE/PROVINCE | ZIP CODE | COUNTRY (IF NOT U.S.)

HOME PHONE | CELL PHONE | EMAIL

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 to avoid registration problems. If you are unable to get a physical done prior to your Orientation, please have your practitioner fill out the immunization information section and return it to us.**

PART I - REQUIRED IMMUNIZATION HISTORY

Please have your physician complete Section I and/or Section II and sign the back. **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

Health Form, Part II and III

Stony Brook University

STUDENT LAST NAME (PLEASE PRINT) FIRST NAME STONY BROOK ID#

PART II - HEALTH HISTORY

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/Hay Fever			
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 _____ 3 Blood Pressure _____ / _____ 4 Pulse _____

5 Vision Right 20/_____ Left 20/_____ Corr. 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 Genitourinary		
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. All information on this form is accurate and correct to the best of my knowledge.

_____

SIGNATURE 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