Health Form

STONY BROOK
STATE UNIVERSITY OF NEW YORK

When Completed, Mail Directly to:
The School of Medicine at Stony Brook University Medical Center
Office of Student Affairs
HSC Level 4, Room 147
Stony Brook, NY 11794-8436
Fax: 631-444-8921
Phone: 631-444-2341

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 this form and return it to address above, ***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 HISTORY

DATE OF BIRTH: _____

SECTION I

List **TWO** dates of "MMR" (Measles, Mumps, Rubella) vaccine inoculation: ..... _____ and _____
(Two doses of live vaccine administered on/after the first birthday after 1/68)

SECTION II

A: MEASLES– items 1 AND 2 MUST be completed

1. **TWO** dates 30 days apart of Measles vaccination:..... _____ and _____
   (Live vaccine administered on or after first birthday after 01/68)

2. Date of blood test for Measles Immunity:..... _____ Result _____
   Pos/Neg

B: MUMPS – items 1 AND 2 MUST be completed

1. **ONE** date of Mumps vaccination: ..... _____
   (Live vaccine administered on or after first birthday after 01/68)

2. Date of blood test for Mumps Immunity: ..... _____ Result _____
   Pos/Neg

C: Rubella – items 1 AND 2 MUST be completed

1. **ONE** date of Rubella vaccination (live vaccine): ..... _____

2. Date of blood test for Rubella Immunity:..... _____ Result _____
   Pos/Neg

D: Heptatitis B – items 1 AND 2 MUST be completed

1. Dates of THREE Doses or signed copy of OSHA mandated declination:..... _____

2. Date of blood test for Hepatitis B Immunity:..... _____ Result _____
   Pos/Neg

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 220/

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:		

Recommended Vaccines	Dates
19 Varicella	
20 Meningococcal (see below)	
SOM Mandatory Vaccines/Lab Tests	**Dates**
21 Tetanus Diphtheria Accellular	
Pertusis (DTAP)	
22 Influenza (annually)	
23 Tetanus (w/in 10 years)	
24 Polio	
25 PPD Mantoux w/in 1 year	Date_____ _____ mm
(If test is positive, chest x-ray required)	Date_____ NA _____
26 BCG 27 Chest X-ray for positive PPD. Attach report	
Date_____ Place _____Result _____ 28 Varicella titer (required if no documented disease history or vaccine available	

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

NYS Public Law 2167 requires universities to distribute information about meningococcal disease and vaccination to all students meeting the enrollment criteria. The law is effective as of August 15, 2003. Colleges in NYS are required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student's parent/guardian. This must include information on the availability and cost of the meningococcal meningitis vaccine;

AND EITHER;

- A record of meningococcal meningitis immunization w/in the past ten years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or parent/guardian.

Stony Brook university requires that all students read the medical information on our website, and complete the response form. The form must be submitted through the SOLAR system.