Health Form - Part Time Students

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 ________________________________________________________________

Emergency Contact __________________________________ Relationship ________________
Cell 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 Form and return it to the Student Health Service before the first day of classes. It is important that we receive the immunization information before that date so your form can be processed early to avoid registration / de-registration problems.

PART I–REQUIRED IMMUNIZATION INFORMATION

Please have your physician complete either Section I and/or Section II and sign.

DATE OF BIRTH: _________ / _________ / _________

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

Physician's Signature/Stamp ________________________ Date ________________