

Health Form–Health Sciences



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

To Students Admitted to the School of Health Technology and Management:

The Health Sciences schools' student health policy **requires** that all students admitted to programs that involve education in clinical settings submit documentation of their health status and immunization history prior to the start of classes. NYS Public Health Law §2165 requires all students in post-secondary education to be **immunized against measles, mumps and rubella**.

In addition, NYS Public Health Law §2167 requires institutions, including colleges and universities, to distribute information about meningococcal disease and vaccination to all students. Students must comply with this law by reading the required information about meningitis and completing the meningococcal vaccination response form available on your SOLAR account.

The Student Health Form has three (3) parts:

Part I – Health History; **Part II** – Physical Examination; **Part III** – Immunization History.

YOU MUST COMPLETE PART I BEFORE GOING TO A HEALTH PRACTITIONER FOR EXAMINATION.

SUBMIT THE COMPLETED FORM TO THE ABOVE ADDRESS AT LEAST 2 WEEKS BEFORE ATTENDING ORIENTATION.

The Registrar will block the registration of any student who is not in compliance. The Health Sciences schools will not authorize students to begin their clinical education unless their physical examination, required laboratory tests, and record of immunizations comply with the requirements listed below.

Requirements for registration and for clinical training include documentation of the following:

- A.** Physical examination completed by a licensed practitioner within six months of starting enrollment (please see pages 3 and 4).
- B.** Required laboratory test results:
 1. **PPD Mantoux** within six months prior to first enrollment; yearly thereafter if negative. If PPD is positive, please submit chest x-ray and record of results, place and date of examination. Students with positive PPD and/or positive chest x-ray will be referred to the Student Health Service for follow-up as appropriate. A copy of the chest x-ray report is required.
 2. **Required Titers** (showing immunity): **Measles, Mumps, Rubella, Varicella and Hepatitis** (unless Hepatitis B vaccine declination statement is signed on page 4 of this form).
 - 2.a. **All required titers must have copies of full laboratory reports attached to the Student Health Form.**
- C. Required immunizations:**
 1. Tetanus or Tetanus/diphtheria (Td) toxoid within the past 10 years
 2. Poliomyelitis vaccine
- D. Strongly recommended immunizations:**
 1. Hepatitis B vaccine
 2. Influenza vaccine
 3. Meningococcal vaccine
 4. Hepatitis A vaccine

PART I-HEALTH HISTORY

Student: Please complete all sections on pages 2 and 3 before going to your health practitioner for examination.

Name _____ Date of Birth _____
(Print) Last Middle First

Sex: Male Female Marital Status: Married Single Other

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

Local/Campus Address (if known) _____ () _____
Telephone

Person to be Notified
in Case of an Emergency _____ () _____
Name and Relationship Home Telephone

Address _____ () _____
Number and Street City/Town State ZIP Code Business Telephone

Name and address of parent, guardian, or spouse *(if different from above)* _____

Address _____ () _____
Number and Street City/Town State ZIP Code Telephone

Physician _____ () _____
Name Telephone

Address _____
Number and Street City/Town State ZIP Code

Where have you lived most of your life? (check one)

- United States Canada Mexico Central America South America Caribbean Europe
- Africa Middle East India Pakistan Far East Australia/New Zealand Other

RELEASE OF INFORMATION AUTHORIZATION

I give authorization for the release of the **Student Health History and Examination Form** to the Office of Student Services, the Dean of the School of _____, the Student Health Service, the Stony Brook University Hospital Employee Health Service Department and other hospitals and clinical affiliates where I might be engaged in clinical instruction as part of my academic training at the Health Sciences schools of Stony Brook University.

Student's Signature

Date

PERMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

When serious medical problems arise, every effort will be made to reach parents, guardians, or spouse. On occasion, we are unable to make this contact. To avoid delay in treatment, we request that the following statement be signed by a parent, legal guardian, or spouse:

I hereby grant permission to treat and/or hospitalize my son/daughter/spouse/ward in case of illness/injury.

Signature of Parent or Guardian or Spouse/Relationship

Date

HEALTH HISTORY

A. FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
1 Father					
2 Mother					
3 Brother(s)					
4 Sister(s)					

	Yes	No	Relationship
5 Tuberculosis			
6 Diabetes			
7 Kidney Disease			
8 Heart Disease			
9 High Blood Pressure			
10 Arthritis			
11 Stomach Disease			
12 Asthma, Hay Fever, Eczema			
13 Epilepsy, Convulsions			
14 Cancer			
15 Emotional Trouble			
16 Anemia			
17 Alcohol/Drug Abuse			

B. PERSONAL HEALTH HISTORY—PLEASE ANSWER ALL QUESTIONS *Comment on all positive responses in space provided below. Y = YES, N = NO*

	Y	N
18 Scarlet Fever Disease		
19 Measles Disease		
20 German Measles Disease		
21 Mumps Disease		
22 Chicken Pox Disease		
23 Mononucleosis		
24 Malaria		
25 Eye Trouble		
26 Ear, Nose, Throat Trouble		
27 Sinusitis		
28 Hearing Difficulty		
29 Speech Difficulty		
30 Diabetes		
31 Insomnia		
32 Frequent Anxiety		
33 Frequent Depression		
34 Worry or Nervousness		
35 Recurrent Headaches		
36 Recurrent Colds		

	Y	N
37 Allergies (specify): Penicillin		
38 Allergies: Other Drugs		
39 Hay Fever, Asthma		
40 Chronic Cough		
41 Rheumatic Fever		
42 Heart Murmur		
43 Pain/Pressure in Chest		
44 Palpitation (Heart)		
45 Shortness of Breath		
46 High Blood Pressure		
47 Dizziness or Fainting		
48 Convulsions or Epilepsy		
49 Weakness, Paralysis		
50 Arthritis, Rheumatism, Joint Trouble		
51 Back Problems		
52 Stomach or Intestinal Trouble		
53 Gallbladder Trouble		
54 Jaundice or Hepatitis (Dental students only: If yes, needs to be tested as a carrier)		

	Y	N
55 Recurrent Diarrhea		
56 Surgery (list with dates in space provided)		
57 Head Injury with Unconsciousness		
58 Rupture, Hernia		
59 Recent Weight Gain		
60 Recent Weight Loss		
61 Tuberculosis or Positive TB Test		
62 Venereal Disease		
63 Albumin in Urine		
64 Sugar in Urine		
65 Frequent Urination		
66 Urinary Tract Infections		
67 Painful Urination		
FEMALES ONLY		
68 Irregular Periods		
69 Severe Cramps		
70 Excessive Flow		
71 Number of Pregnancies		
72 Number of Live Births		

	Y	N
73 Has your physical activity been restricted or your education interrupted for medical reasons during the past five years?		
74 Have you had difficulty with school, studies, or teachers?		
75 Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?		
76 Have you had any illness or injury or been hospitalized other than already noted? (Describe below.)		
77 Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (other than routine checkups)?		
78 Have you been rejected for or discharged from military service because of physical, emotional, or other reasons?		
79 Do you have the absence of any paired organ (eye, ear, kidney, etc.)?		
80 Do you have a history or are presently dependent on drugs or alcohol?		

C. MEDICATION

Are you currently taking any medication? Yes No Please list (including birth control pills):

COMMENTS:

Practitioner Signature _____

(Acknowledging Review of Health History)

