Health Form–Health Sciences

Stony Brook University

Please upload the document to the health portal:

Go to Wolfie Health Portal at:
https://stonybrook.medicatconnect.com

Questions about vaccination requirements contact:
(vaccinations@stonybrook.edu)

Student Health Services
Tel: (631) 632-6740
tdd: (631) 632-6171

To Students Admitted to the School of Health Professions:

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, QuantiFERON- TB Gold or IGRA** within six months prior to first enrollment; yearly thereafter if negative. If PPD or **QuantiFERON** is positive, please submit chest x-ray and record of results, place and date of examination. Students with positive PPD and/or positivechest 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. TDAP (TETANUS DIPHTHERIA ACELLULAR PERTUSSIS) within the past 10 years
2. Poliomyelitis vaccine
3. COVID-19 vaccine
4. COVID-19 booster *(when eligible)*

CI. Strongly recommended immunizations:

1. Hepatitis B vaccine
2. Influenza vaccine
3. Meningococcal vaccine
4. Hepatitis A vaccine

HSC School/Program_____ **Stony Brook ID No.** _____

PART I–HEALTH HISTORY

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

Legal Name _____
Print Last Middle First

Preferred Name _____ Date of Birth _____
Print Last Middle First

Gender: ❑ Male ❑ Female ❑ Nonbinary

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 (please specify) ____

RELEASE OF INFORMATION AUTHORIZATION

I give authorization for the release of the ***Student Health History and Examination Form*** to 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)

STUDENT'S NAME _____ **STONY BROOK ID No.** _____

DATE OF BIRTH _____

Major/Program (check one item below)

❑ AT ❑ CLS ❑ DIETETIC ❑ NUC MED ❑ PA ❑PT ❑ RC
❑ ANESTH ❑ DENTAL ❑ MED DOS ❑ OT ❑ PARAMEDIC ❑ Radiation Therapy ❑ RAD TEC ❑ OTHER _____

To the Examining Practitioner:

PART II–PHYSICAL EXAMINATION

Please review the student's history and complete applicable parts of the examination form. Please comment on all positive answers. THIS STUDENT HAS BEEN ADMITTED TO THE UNIVERSITY. The information will not be used to influence status at the University; it will be used only as a background for providing health care, if necessary, while enrolled as a student. This information is confidential. It will not be released to anyone without the student's knowledge and consent. However, after the student signs consent, this form can be sent to Stony Brook University Hospital and clinical affiliates.

1 Height_____2 Weight_____3 Blood Pressure_____/_____4 Pulse _____

5 Vision Right 20/ Corr. 20/
Left 20/ to 20/

Describe any abnormalities of the following systems 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		

	Yes	No
19 To the best of your knowledge, is this person free from physical or mental impairments, including alcohol or drug dependency?		
20 Are there any restrictions of physical activity indicated by your examination? Comment.		
21 Is the patient now under treatment for any medical or emotional condition? Comment.		
22 Do you have any recommendations regarding the care of this student? Comment.		
23 How long and in what capacity have you known this student?		

PART III–IMMUNIZATION HISTORY

IMMUNIZATIONS REQUIRED	Dates of Injections		
IF DATE OF BIRTH IS PRIOR TO 1/1/57, ANSWER 28-42			
IF DATE OF BIRTH IS AFTER 1/1/57, ANSWER 24-42			
Two Measles Vaccines Required			
24 MMR-MEASLES/MUMPS/RUBELLA (TWO)			
25 MEASLES VACCINE (TWO IMMUNIZATIONS)			
26 MUMPS VACCINE			
27 RUBELLA VACCINE			
28 TDAP (TETANUS DIPHTHERIA ACELLULAR PERTUSSIS) WITHIN 10 YEARS			
29 POLIO ❑ SALK ❑ SABIN			
30 COVID-19 VACCINE			
31 COVID-19 BOOSTER (*when eligible*)			
TITERS REQUIRED (attach copies of reports)	Date	Pos	Neg
33 Measles Titer (Rubeola)			
34 Mumps Titer			
35 Rubella Titer (German Measles)			
36 Varicella Titer (Chicken Pox)			
37 Hepatitis B Titer (unless declination is signed) *			

LABORATORY FINDINGS: MANDATORY	
38 PPD Tuberculosis Mantoux, QuantiFERON- TB GOLD or IGRA test within 6 (months - (mandatory) If test is positive, chest x-ray is required) Date _____mm	
39 Chest x-ray (if positive PPD, QuantiFERON- TB or IGRA **attach report**) Date _____mm Place_____ Result _____ Treatment _____	
40 BCG VACCINE Date _____ NA _____	
IMMUNIZATIONS STRONGLY RECOMMENDED	Dates of Injections
41 HEPATITIS B (SERIES OF 3 INJECTIONS)	
42 INFLUENZA	
43 MENINGOCOCCAL VACCINE	
44 HEPATITIS A	
45 HPV VACCINE	
46 OTHER:	

***Hepatitis B Vaccine Declination**

I understand that I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have been *given* the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series by Student Health Service.

_____
Student's Signature Date

Examining Practitioner:

Public health regulations require that hospitals ensure that their personnel are "free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his or her duties" 10 NYCRR 405.3(b)(10).

Student meets the above requirement. ❒ Yes ❒ No

Examining Practitioner Signature_____Date of Examination_____

Name_____Telephone No. (include area code) (__)_____Address_____

_____Zip _____