When Completed, Mail Directly to:
Director, Student Health Service
Stony Brook University
Stony Brook, New York 11794-3191

Stony Brook University

STUDENT HEALTH SERVICE
Tel: (631) 632-6740
TDD: (631) 632-6171
Fax: (631) 632-6936

Health Form

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

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

HOME PHONE | CELL PHONE | E-MAIL

EMERGENCY CONTACT | RELATIONSHIP | PHONE

This Health Form must be completed by your practitioner and must be received by the Student Health Service before the first day of classes. If you are under the age of 18 the consent for treatment on this form must be signed by your parent or guardian.

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 | RELATIONSHIP | PHONE | DATE

HEALTH HISTORY

Current Medications:

Chronic Medical Conditions:

Allergies (including drug and other):

Psychological Conditions:

Surgical Procedures:

PHYSICAL EXAMINATION

Height _____ Weight _____ Vision Right 20/_____ Corr. Right 20/_____

Blood Pressure _____ / _____ Pulse _____ Left 20/_____ Corr. left 20/_____

	Normal	Abnormal
Head, Eyes, Ears, Nose, Throat		
Neck-Thyroid		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genito-urinary/Hernia		
Musculoskeletal		
Neuropsychiatric		
Skin		
Comments:		

Recommended Vaccines	Dates		
HPV VACCINE	#1	#2	#3
HEPATITIS A	#1	#2	
HEPATITIS B	#1	#2	#3
VARICELLA	#1	#2	or Date Had Disease
MENINGOCOCCAL TYPE			
TETANUS (within 10 years)			
TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (TDAP)			
POLIO			
PPD Mantoux (if test is positive, chest X-ray is required)	Date_____	_____mm	
BCG	Date_____	NA_____	
Chest X-ray (if positive PPD, please attach report) Date_____ Place_____ Result_____ If chest X-ray was positive was/is patient on INH Treatment? ☐ Yes ☐ No			

I have reviewed all sections of this Health Form including the immunization information. I acknowledge, to the best of my knowledge, that the information on this form is accurate and correct.

SIGNATURE EXAMINING PRACTITIONER ☐ MD / ☐ PA / ☐ NP DATE PRINT NAME

ADDRESS **PRACTITIONER STAMP:**

TELEPHONE NO. (INCLUDING AREA CODE)

PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS BEFORE YOU SEND IT IN.