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

Immunization 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 ______

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. Have your physician's office complete this form and return it to the Student Health Service **TWO WEEKS PRIOR TO YOUR ORIENTATION DATE**, so your form can be processed early to avoid registration/de-registration problems. If you are unable to get your physician to fill this out, immunization information can be obtained from other sources: Sources such as your high school health office, previous college health service (transfer students), or infant immunization records held by parents that are signed by a physician will be accepted and need to be attached to this form.

The Health Form (Health History and Physical Form) must be completed by your physician and returned to the Student Health Service before the first day of classes.

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

DATE OF BIRTH: ________ /________ /________
MONTH DAY YEAR

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 ______

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 ______ DATE ______

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