

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: _____ / _____ / _____ <small style="text-align: center;">MONTH DAY YEAR</small>
SECTION I List TWO dates of "MMR" (Measles, Mumps, Rubella) vaccine inoculation _____ and _____ <i>(Two doses of live vaccine administered on or after the first birthday after 1/68)</i> 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 _____ <i>(Live vaccine administered on or after the first birthday after 1/68)</i> 2. Approximate date of Measles infection (disease) _____ 3. Date of blood test for Measles Immunity _____ Results _____ <div style="text-align: right;">Pos/Neg/Equiv</div>	
B: MUMPS—complete ONE of the following: 1. ONE date of Mumps vaccination _____ <i>(Live vaccine administered on or after the first birthday after 1/69)</i> 2. Approximate date of Mumps infection (disease) _____ 3. Date of blood test for Mumps Immunity _____ Results _____ <div style="text-align: right;">Pos/Neg/Equiv</div>	
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 _____ <div style="text-align: right;">Pos/Neg/Equiv</div>	
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
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PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS BEFORE YOU SEND IT IN.