

**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

# 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
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## 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	Recommended Vaccines	Dates
Head, Eyes, Ears, Nose, Throat			HPV VACCINE	#1 #2 #3
Neck-Thyroid			HEPATITIS A	#1 #2
Respiratory			HEPATITIS B	#1 #2 #3
Cardiovascular			VARICELLA	#1 #2 or Date Had Disease
Gastrointestinal			MENINGOCOCCAL TYPE	
Genito-urinary/Hernia			TETANUS (within 10 years)	
Musculoskeletal			TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (TDAP)	
Neuropsychiatric			POLIO	
Skin			PPD Mantoux (if test is positive, chest X-ray is required)	Date_____ mm
Comments:			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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> MD / <input type="checkbox"/> PA / <input type="checkbox"/> 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.**