

Immunization Form



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

Name _____ ID# _____
 (Print) Last First Middle
 Home Address _____ () _____
 Number and Street City/Town State Zip Code Home Telephone
 E-Mail Address _____ () _____
 Cell Phone
 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 if you are required to attend one.** All others must submit this form on or before the first day of classes. This is 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 copied and 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.**

REQUIRED IMMUNIZATION INFORMATION Please have your physician complete either Section I and/or Section II and sign.	DATE OF BIRTH ____/____/____
List TWO date of "MMR" (Measles, Mumps, Rubella) vaccine inoculation:..... (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.	_____ and _____
OR: A: MEASLES—complete ONE of the following: 1. TWO dates 30 days apart of Measles vaccination: (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:.....	_____ and _____ _____ 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:.....	_____ and _____ _____ 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.