Stony Brook Medicine

Health Form

For Visiting Students

When completed, mail directly to:
Lorraine Reeve
Office of Undergraduate Medical Education
Stony Brook University School of Medicine
Stony Brook, NY 11794-8432

Visiting students must use this form.To the Examining Practitioner:
Please review the student's history and complete this examination form. This information is confidential. It will not be released to anyone without the student's knowledge and consent.

Student Name _____ Social Security _____ - _____ - _____

Student Birth Date _____ (Will be used to verify immunizations when necessary)

Name of Student's Home Institution _____

Name of Examining Physician (Please print or type) _____

I examined the above named student on (Date) _____. The student is in good health and does not pose a health risk to patients or employees at the Hospital.

Signature of Physician _____ Date of Exam _____
Examining Practitioner

Address _____ Telephone No. (_____) _____ - _____

Verification of Immunizations/Immunity Information:

MMR: Titres are required if vaccination dates are not available

Rubeola (Measles) (Dates) _____ _____
Titre results _____ (Date) _____ Positive _____ Negative_____

Rubella (German Measles) (Dates) _____
Titre results _____ (Date) _____ Positive_____ Negative_____

Mumps (Dates) _____
Titre results_____ (Date) _____ Positive_____ Negative_____

Varicella: Two (2) doses of vaccine or positive Titre is required
Varicella Vaccine Dates _____ _____
Varicella Titre Positive_____ Negative _____ Date _____

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PPD Mantoux: within 1 year mandatory (if test is positive, chest X-Ray is required)
Date _____ Positive ____ Negative _____ _____mm

Chest X-Ray (if positive PPD attach report)
Date _____
Place _____
Result _____

Tetanus: Booster or Td within 10 years (Date) _____

Hepatitis B: vaccine (Dates) _____ _____ _____
(Proof of 3 doses, copy of anti-HBs titer, or signed copy of OSHA mandated declination certificate required)

***Hepatitis B Vaccine Declination:**
I understand that I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signed_____ Date_____

Meningitis Vaccine
I have had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date received: _____

***Meningitis Vaccine Declination:**
I read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____

Influenza (highly recommended) Date _____

I have attached a photocopy of my health insurance card, which provides coverage while I rotate at University Hospital at Stony Brook.

Student Signature _____ Date_____

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Verification of Immunizations/Immunity Information by:

Physician Signature _____ Date signed_____
Examining Practitioner

Physician Name (Please print or type) _____

Address _____ Zip _____

Telephone No. (Please include area code) _____