Stony Brook University

STUDENT HEALTH SERVICES
Tel: (631) 632-6740

Immunization Form

STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE INITIAL	STONY BROOK ID#

HOME ADDRESS	STREET/APT.#	CITY/TOWN	STATE/PROVINCE	ZIP CODE	COUNTRY (IF NOT U.S.)

HOME PHONE	CELL PHONE	DATE OF BIRTH

For the health and safety of the campus community, New York State Public Health Law and Stony Brook University policy require all students attending at least one in-person class, living on campus, or accessing in-person services or facilities on Stony Brook University's campuses to comply with mandatory health requirements.

The **mandatory** requirements below must be satisfied as soon as possible to have your hold removed and be able to register for classes. For more information, visit **http://www.stonybrook.edu/immunizations**.

To ensure your documents are processed, please print LEGIBLY and obtain the required SIGNATURE OR STAMP of a healthcare provider. Please upload the completed documents to the Wolfie Health Portal at https://stonybrook.medicatconnect.com

REQUIRED IMMUNIZATIONS: *To be completed by a healthcare provider*

1. MMR (Measles, Mumps, Rubella) Requirement:

o Dose 1 (Not immunized prior to first birthday and after 1971) Dose#1 Date ____/____/_____ **DATE OF BIRTH**_____/____/____

o Dose 2 (Immunized as above and at least 28 days after the first dose) Dose #2 Date ____/____/_____

OR

Serologic evidence of immunity for each disease– Laboratory report verifying (IgG) to measles, mumps and rubella are required (titers).
LAB REPORTS MUST BE ATTACHED.
Note: If student is a Medical, Dental, Nursing, or clinical Health Technology and Management student, serologic evidence of immunity (titers) to measles, mumps, rubella, varicella, and hepatitis B will be required for clinical rotations. Please check with your school to see if there are other required immunizations.

2. Meningitis Vaccination Response Form Requirement:

Students may comply with New York State Public Health Law 2167 regarding meningitis by reading the required information regarding meningitis at this Web site: www.health.ny.gov/ publications/2168.pdf and then completing this form. Check one box and sign below. I have (for students under the age of 18: My child has):

□ Had the meningococcal meningitis immunization within the past 5 years. Please indicate the immunization dates below:

Meningococcal ACYW135 Dose #1 Date ____/____/___ Dose #2 Date ____/____/___

OR

Meningococcal Type B Dose #1 Date ____/____/____ Dose #2 Date ____/____/___

□ 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 (my child) will not obtain immunization against meningococcal meningitis disease.

_____ _____

Signature of student (if 18 or older) / parent or guardian (if student is under 18) Date

RECOMMENDED IMMUNIZATIONS:

Please visit **http://www.stonybrook.edu/shs** for recommended vaccines and screenings or scan this QR code:

Healthcare Provider Signature: (MD/NP/PA):_____ Date:_____ Stamp:

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 Services to evaluate, treat, or secure a referral to an outside agency for my child/ward in case of illness/injury. I also hereby grant permission to immunize my child/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	RELATIONSHIP	PHONE	DATE