

School of Dental Medicine Health Form



Stony Brook
School of Dental Medicine

Student Health Service

Tel: (631) 632-6740

(631) 632-6171

Dear Student,

Student health policy **requires** that all students admitted to programs that involve education in clinical settings submit documentation of their health status and immunization history prior to the start of classes. NYS Public Health Law §2165 requires all students in postsecondary education to be **immunized against measles, mumps and rubella.**

In addition, NYS Public Health Law §2167 requires institutions, including colleges and universities, to distribute information to all students about meningococcal disease and vaccination. Students must comply with this law by **reading the required information about meningitis and completing the meningococcal vaccination response form available on their SOLAR accounts.**

A HEALTH UPDATE IS REQUIRED ANNUALLY.

The Student Health Form has three (3) parts:

Part I Health History • **Part II** Physical Examination • **Part III** Immunization History

The registrar will block the registration of any student who is not in compliance. The health sciences schools will not authorize students to begin clinical education unless their physical examination, required laboratory tests and record of immunizations comply with the requirements listed below.

Requirements for registration and clinical training include documentation of the following:

A. Physical examination completed by a licensed practitioner within six months of starting enrollment (please see pages 3 and 4).

B. Required laboratory test results:

1. **PPD Mantoux** within six months prior to first enrollment; yearly thereafter if negative. If PPD is positive, please submit chest x-ray and record of results, place and date of examination. Students with positive PPD and/or positive chest x-ray will be referred to the Student Health Service for follow-up as appropriate. A copy of the chest x-ray report is required.

2. **Required titers** (showing immunity): **Measles, Mumps, Rubella, Varicella and Hepatitis** (unless Hepatitis B vaccine declination statement is signed on page 4 of this form).

Note: All required titers must have copies of full laboratory reports attached to the Student Health Form.

C. Required immunizations:

1. Measles
2. Mumps
3. Rubella

D. Strongly recommended immunizations:

1. Hepatitis B vaccine
2. Influenza vaccine
3. Meningococcal vaccine
4. Hepatitis A vaccine
5. Tetanus or tetanus/diphtheria (Td) toxoid within the past 10 years
6. Poliomyelitis vaccine

PART I — HEALTH HISTORY

Student: Please complete all sections on pages 2 and 3 before going to your health practitioner for an examination.

Name _____ Date of Birth _____
(Print) Last Middle First

Sex: Male Female

Home Address _____ () _____
Number and Street City/Town State Zip Code Home Telephone

Local/Campus Address (if known) _____ () _____
Telephone

Person to be Notified
in Case of an Emergency _____ () _____
Name and Relationship Home Telephone

Address _____ () _____
Number and Street City/Town State Zip Code Business Telephone

Name and address of parent, guardian or spouse (if different from above) _____

Address _____ () _____
Number and Street City/Town State Zip Code Telephone

Physician _____ () _____
Name Telephone

Address _____
Number and Street City/Town State Zip Code

A. FAMILY HISTORY

	Age	State of Health	Occupation	Living or Deceased	Age at Death	Cause of Death
1 Father						
2 Mother						
3 Brother(s)						
4 Sister(s)						

HEALTH HISTORY

B. PERSONAL HEALTH HISTORY — PLEASE ANSWER ALL QUESTIONS Comment on all positive responses in the space provided below. **Y=YES, N=NO**

	Y	N
5 Albumin in Urine		
6 Alcohol/Drug Abuse		
7 Allergies (specify): Penicillin		
8 Allergies: Other Drugs		
9 Anemia		
10 Arthritis		
11 Arthritis, Rheumatism, Joint Trouble		
12 Asthma, Hay Fever, Eczema		
13 Back Problems		
14 Cancer		
15 Chicken Pox		
16 Chronic Cough		
17 Clotting Disorder		
18 Diabetes		
19 Dizziness or Fainting		
20 Ear, Nose, Throat Trouble		
21 Eating Disorder		
22 Emotional Trouble		
23 Epilepsy, Convulsions/Seizures		
24 Eye Trouble		
25 Frequent Anxiety		
26 Frequent Depression/Mood Disorder		
27 Frequent Urination		
28 Gallbladder Trouble		
29 German Measles		
30 Hay Fever, Asthma		

	Y	N
31 Head Injury with Unconsciousness		
32 Hearing Difficulty		
33 Heart Disease		
34 Heart Murmur		
35 High Blood Pressure		
36 Insomnia		
37 Jaundice or Hepatitis (if yes, must be tested as a carrier)		
38 Kidney Disease		
39 Low Blood Pressure		
40 Malaria		
41 Measles		
42 Mononucleosis		
43 Mumps		
44 Pain/Pressure in Chest		
45 Painful Urination		
46 Palpitations (Heart)		
47 Positive TB Test		
48 Recent Weight Gain		
49 Recent Weight Loss		
50 Recurrent Colds		
51 Recurrent Diarrhea		
52 Recurrent Headaches		
53 Rheumatic Fever		
54 Rupture, Hernia		
55 Scarlet Fever		

	Y	N
56 Sexually Transmitted Infection		
57 Shortness of Breath		
58 Sinusitis		
59 Speech Difficulty		
60 Stomach Disease		
61 Stomach or Intestinal Trouble		
62 Sugar in Urine		
63 Surgery (list with dates in space provided)		
64 Thyroid Problem		
65 Tuberculosis		
66 Urinary Tract Infections		
67 Weakness, Paralysis		
68 Worry or Nervousness		

FEMALES ONLY	Y	N
69 Excessive Flow		
70 Irregular Periods		
71 Number of Live Births		
72 Number of Pregnancies		
73 Severe Cramps		

	Y	N
74 Has your physical activity been restricted or your education interrupted for medical reasons during the past five years?		
75 Have you had difficulty with school, studies or teachers?		
76 Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?		
77 Have you had any illness or injury or been hospitalized other than already noted? (Describe below.)		
78 Have you consulted with or been treated by clinics, physicians, healers or other practitioners within the past five years (other than for routine checkups)?		
79 Have you been rejected for or discharged from military service because of physical, emotional or other reasons?		
80 Are you missing any paired organ (eye, ear, kidney, etc.)?		
81 Do you have a history of or are currently dependent on drugs or alcohol?		

C. MEDICATION

Are you currently taking any medication? Yes No Please list (including birth control pills):

COMMENTS:

Practitioner's Signature _____

(Acknowledging Review of Health History)

PART II — PHYSICAL EXAMINATION

To the Examining Practitioner:

Please review the student's history and complete applicable parts of the examination form. Please comment on all positive answers. THIS STUDENT HAS BEEN ADMITTED TO STONY BROOK UNIVERSITY'S SCHOOL OF DENTAL MEDICINE. The information will not be used to influence status at the University; it will be used only as a background for providing healthcare, if necessary, while enrolled as a student. This information is confidential. It will not be released to anyone without the student's knowledge and consent. However, after the student signs consent, this form can be sent to Stony Brook University Hospital and its clinical affiliates.

1 Height _____ 2 Weight _____ 3 Blood Pressure _____ / _____ 4 Pulse _____
 5 Vision Right 20/ _____ Corr. 20/ _____
 Left 20/ _____ to 20/ _____

Describe any abnormalities below:

	Normal	Abnormal
6 Head, Ears, Nose or Throat		
7 Eyes (with Ophthalmoscope)		
8 Hearing		
9 Neck-Thyroid		
10 Respiratory		
11 Cardiovascular		
12 Gastrointestinal		

	Normal	Abnormal
13 Hernia		
14 Genitourinary		
15 Musculoskeletal		
16 Metabolic/Endocrine		
17 Neuropsychiatric		
18 Skin		

	Yes	No
19 To the best of your knowledge, is this person free from physical or mental impairments, including alcohol or drug dependency?		
20 Are there any restrictions of physical activity indicated by your examination? Comment.		
21 Is the patient now under treatment for any medical or emotional condition? Comment.		
22 Do you have any recommendations regarding the care of this student? Comment.		
23 How long and in what capacity have you known this student?		

PART III — IMMUNIZATION HISTORY

IMMUNIZATIONS REQUIRED	Dates of Injections		
IF DATE OF BIRTH IS PRIOR TO 1/1/57, ANSWER 28-42			
IF DATE OF BIRTH IS AFTER 1/1/57, ANSWER 24-42			
Two Measles Vaccines Required			
24 MMR-MEASLES/MUMPS/RUBELLA (TWO)			
25 MEASLES VACCINE (TWO IMMUNIZATIONS)			
26 MUMPS VACCINE			
27 RUBELLA VACCINE			
28 POLIO <input type="checkbox"/> SALK <input type="checkbox"/> SABIN			
TITERS REQUIRED (attach copies of reports)	Date	Pos.	Neg.
29 Measles Titer (Rubeola)			
30 Mumps Titer			
31 Rubella Titer (German Measles)			
32 Varicella Titer (Chicken Pox)			
33 Hepatitis B Titer (unless declination is signed)			

LABORATORY FINDINGS: MANDATORY	
34 PPD Tuberculosis Mantoux within six months (if positive, chest x-ray is required) Date _____ mm	
35 Chest x-ray (if positive, PPD attach report) Date _____ mm Place _____ Result _____ Treatment _____	
36 BCG VACCINE (if received) Date _____ NA _____	
IMMUNIZATIONS STRONGLY RECOMMENDED	Dates of Injections
37 HEPATITIS B (SERIES OF THREE INJECTIONS)	
38 INFLUENZA	
39 MENINGOCOCCAL VACCINE	
40 HEPATITIS A	
41 HPV VACCINE	
42 TDAP (TETANUS DIPHTHERIA ACELLULAR PERTUSSIS)	
43 TETANUS OR Td (WITHIN 10 YEARS)	
44 OTHER:	

Examining Practitioner:
 Public health regulations require hospitals to ensure that their personnel are "free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his or her duties." — 10 NYCRR 405.3(b)(10)
 Student meets the above requirement.
 Yes No

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. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series by Student Health Service.

 Student's Signature Date

Examining Practitioner's Signature _____ Date of Examination _____

Name _____ Telephone No. (include area code) (____) _____

Address _____ Zip Code _____