DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Office of Diversity Education and Research
450 Clarkson Avenue, MSC 1186 Brooklyn, NY 11203
Phone: (718) 270-3033 / Fax: (718) 270-1929

Health Statement Form for Visiting Students

NOTE: This form must be printed, filed out, and mailed or faxed to the address above.

Completion of this entire form is required of every student coming to SUNY Downstate Medical Center for electives/ research. Please note that a recent Mantoux test or Quantiferon-Gold and chest x-ray (if needed), as well as immunity to measles, mumps, and rubella are required by New York State Health Code. In addition, as indicated in item 4, education and immunization for hepatitis B is required.

Name: ID#: _____

School: _____ DOB: _/___/____
mm/dd/yyyy

Elective at SUNY: Elective Dates: / / to / /
(mm/dd/yyyy) (mm/dd/yyyy)

In order to comply with Federal OSHA regulation, SUNY Downstate Medical Center requires that students receive education regarding exposure to blood, body fluids and other potentially infectious materials before coming to this Medical Center. I have participated in a OSHA Training Education program.

Yes No

To the Health Provider:

1. Does this student have any acute or chronic health problems? If yes, please explain.

_____

_____

2. Date of last physical exam (must be no more than 1 year prior to start of elective): __/__/___ (mm/dd/yyyy)
Result of exam:

_____

_____

3. **PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA IS REQUIRED BY NEW YORK STATE LAW.** Two (2) doses of live measles, mumps and rubella vaccines are required, with the first dose on or after the first birthday, second dose on or after 15 months of age, and at least 30 days after the first dose. Immune titers satisfy this requirement:

MMR vaccine:	___/___/___ #1 date (mm/dd/yyyy)		___/___/___ #2 date (mm/dd/yyyy)
Measles Titer:	_____ POS	_____ NEG	___/___/___ Date (mm/dd/yyyy)
Mumps Titer:	_____ POS	_____ NEG	___/___/___ Date (mm/dd/yyyy)

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Rubella Titer: _____ POS _____ NEG ___/___/___ Date (mm/dd/yyyy)

Please include copies of LAB SLIPS.

4. Documentation of three doses of hepatitis B vaccine and/or positive hepatitis B antibody titer is required.

HBsAb Date:___/___/___ (mm/dd/yyyy) Result:_____

Hepatitis B vaccine (3 doses required) *List Dates:*
___/___/___ (mm/dd/yyyy) _____
___/___/___ (mm/dd/yyyy) _____
___/___/___ (mm/dd/yyyy)

5. HISTORY OF VARICELLA?

YES NO OR TITER _____

IF NO HISTORY OF VARICELLA AND NEGATIVE TITER, TWO DOSES OF VARICELLA VACCINE ARE REQUIRED.

DATES: ___/___/___ dose 1 (mm/dd/yyyy) ___/___/___ dose 2 (mm/dd/yyyy)

6. **TUBERCULIN TEST** (if known negative, Mantoux test or Quantiferon-GOLD must be administered within 6 months prior to elective)

Date:___/___/___ (mm/dd/yyyy) Result:_____mm induration Manufacturer & Lot # _____

CHEST X-RAY (Required if mantoux test is positive): Date:___/___/___ (mm/dd/yyyy) Result:_____

7. **Tdap** Required within the past ten (10) years unless medically contraindicated.

Tdap: Date:___/___/___ (mm/dd/yyyy)

Td: (only if contraindication exists) Date:_____/___/___ (mm/dd/yyyy)

If Tdap is medically contraindicated, state the reason:

I certify that the above statements are true

Name of Health Care Provider: _____
Signature of Health Care Provider: _____
State and License #: _____
Address: _____
Telephone #: _____
Date: ___/___/___

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Return this form to the Office of Diversity Education and Research- 450 Clarkson Avenue, MSC 1186 Brooklyn, NY 11203, email it to diversityprograms@downstate.edu or fax it to (718) 270 1929. Failure to do so will delay your enrollment into the program.