Student / Employee Health Service

SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY
HEALTH STATEMENT FOR VISITING STUDENTS

Completion of this form is required of all students coming to SUNY Downstate Health Sciences University for electives. It must be submitted with your application. Please note that immunity to measles, mumps, and rubella is required by New York State Health Code. In addition, as indicated in item 4, education and immunization (or declination) for hepatitis B is required by OSHA.

NAME: SID# (if applicable) DOB:

SCHOOL/COLLEGE: ELECTIVE OR INTERNSHIP AT SUNY DOWNSTATE: DATES OF ELECTIVE:

TO THE HEALTH PROVIDER:

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

a. Is the student currently taking any prescription medications?

b. Does the student have any special dietary needs? Please specify.

c. Does the student have any allergies to food or medicine? Please specify.

2. Date of last physical exam (must be no more that 1 year prior to start of elective):

Result of exam:

3. PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA IS REQUIRED BY NEW YORK STATE LAW. ONE DOSE OF LIVE MUMPS AND RUBELLA VACCINES AFTER FIRST BIRTHDAY, 2 DOSES OF LIVE MEASLES VACCINE AFTER FIRST BIRTHDAY, OR IMMUNE TITERS WILL SATISFY THIS REQUIREMENT.

Measles vaccine: _____ _____ or titer_____
#1 date #2 date

Mumps vaccine _____ or titer_____
date

Rubella vaccine _____ or titer_____
date

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450 Clarkson Avenue, Box 33, Brooklyn, NY 11203-2098 • 718 270-1995 / 1969 • Fax 718 270-2477

4. FOR ANY STUDENT WORKING WITH BLOOD OR BODY TISSUES OR HAVING DIRECT PATIENT CONTACT THE FOLLOWING INSTRUCTIONS APPLY: In order to comply with Federal OSHA regulations SUNY Downstate Health Sciences University requires that you receive education regarding exposure to blood, body fluids and other potentially infectious materials before coming to this medical center. You must also have documentation of three doses of hepatitis B vaccine, positive hepatitis B antibody titer or a signed declination form attached to this health form.

HBsAb_____ Hepatitis B vaccine dates (3 doses required)

_____ _____ _____

or Declination Form enclosed_____

5. HISTORY OF VARICELLA? _____YES _____NO or TITER _____

VARICELLA VACCINE _____ _____
date #1 date #2

6. TUBERCULIN TEST (If known negative, QuantiFERON-TB Gold test or Mantoux test must be done or administered within 6 months prior to elective).

Date: Result:_____mm induration, Manufacturer & Lot #_____

Chest X-ray (required if TB Test positive): Date: Result:

7. HEPATITIS A VACCINE (At least one dose is required--2 weeks or more prior to departure; Non-applicable for British Exchange Program)

_____ _____
dose 1, date dose 2, date

8. ADULT TETANUS/DIPHTHERIA (T/d) booster required in past 10 years. _____
date

I certify that the above statements are true.

SIGNATURE OF HEALTH CARE PROVIDER:

STATE & LIC. #:

ADDRESS:

TELEPHONE: DATE:

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