**STATE UNIVERSITY OF NEW YORK**
**DOWNSTATE HEALTH SCIENCES UNIVERSITY**

**Student Health Center**

**440 Lenox Road, Ste 1W, Brooklyn, NY 11203**
**Phone: 718.270.2018**

# Health Statement Form

# Visiting Students/Student Interns

Completion of this entire form is required of every student coming to SUNY Downstate Medical Center for electives. 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) |

| | | | |
|---|---|---|---|
| **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:

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**I certify that the above statements are true and that this student has received the mandatory education as per OSHA regulation. (Please note: International Visiting Students will complete OSHA training on site.)**

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

**Return this form to the Student Health Center, 440 Lenox Road, Suite 1W, Brooklyn, NY 11203.**