High School/Medical School Shadowing Program

MEDICAL RECORD FORM

Student Name ____

In order that we may be aware of any particular medical problem while your child is at Stony Brook, please complete the following:

Does your child suffer or has your child suffered from:

______ High blood pressure
______ Asthma or other chest or lung problem
______ Epilepsy
______ Hearing problems
______ Stomach problems
______ Rheumatic fever

______ Diabetes
______ Allergies (explain)
______ Menstrual problems
______ Other - please indicate
____

Is your son/daughter taking any medication on a regular basis? ______ yes _____ no
If so, medication used ________________________ How frequently? ______________
For what condition: ________________________ Additional comments: __________
____

Name of family doctor ________________________ Phone ______________________
Date of child's last physical ________________________

IMMUNIZATIONS

Public Health Law 2165 requires immunization history of measles, mumps, and rubella must be mailed to us before you arrive and completed and signed by your physician or clinic.

	DATE	NEG	POS
PPD Mantoux within one year (if test is positive, chest x-ray is required)			___mm

	DATES
Tetanus or TD within 10 years	______________
MMR combined measles, mumps, rubella	______________
OR	
Measles vaccine (two immunizations)	______________
Mumps vaccine	______________
Rubella vaccine	______________
Polio ❍Salk ❍Sabin	______________

____
Signature of Physician

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PARENTAL CONSENT FORM
PLEASE PRINT

Name: ______________________________

Social Security Number: ________________

High School: _________________________

Parent/Guardian ______________________

Home telephone: ______________________ Work telephone: ________________

The High School/Medical School Shadowing program will offer students an opportunity to learn about basic science and medicine. Students will interact with Stony Brook faculty, physicians, medical students, and other high school students in the University Hospital. Although every safety precaution will be taken, certain hazards remain and risks of physical injury and/or property damage, while minimal, do exist in such a program.

I understand that the State University of New York at Stony Brook does not carry liability, medical or property damage insurance in these cases, and that the primary responsibility in case of accident will be provided by myself and/or my own insurance.

Name of Insured: ____

Insurance Carrier: ____

Address of Insurance Carrier: ____

Group #: ____________________ ID#___________________________________

If no medical coverage, check here ○

By signing this statement I indicate that I understand the nature of the program and its risks, and grant permission to SUNY at Stony Brook to allow my child to participate in the High School/Medical School Shadowing program.

Signature of Parent/Guardian ___________________________ Date ___________

High School/Medical School Shadowing Program

PERMISSION FORM

PLEASE PRINT

I grant my child, ___________________, permission to participate in the High School/Medical School Shadowing program at Stony Brook University. I grant permission to the program, the University Health Service and its staff to treat as necessary and/or secure proper treatment for my child in case of illness. Emergency treatment can be given at the University Hospital at Stony Brook.

Please contact the following in case of emergency:

Parent/Guardian Name: ____

Home telephone: ____

Work telephone: ____

Name of relative or friend: ____

Telephone: ____

Signature of Parent/Guardian: ____

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CONFIDENTIALITY STATEMENT

I am a high school student enrolled in the High School/Medical School Shadowing Program. As part of this program I will be observing physicians assigned to the program. I understand that any patient names, films, reports, and records, etc. being reviewed are strictly confidential.

____
Student Name (print)

____
Student Signature

____
School Name & Location

____
Parent/Guardian Name (print)

____
Parent Signature

High School/Medical School Shadowing Program

PHOTOGRAPH RELEASE

I give permission to Stony Brook University to take photographs of my child, ______________________________, who is enrolled in the High School/Medical School Shadowing program in 2004. I understand that these photographs may be used in brochures and other promotional material, including electronic media such as the Internet, for the express purpose of promoting the State University of New York at Stony Brook and its programs.

____
Student Signature

____
Parent Signature

____
Date