LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT.
Wellness Center
for Health and Counseling

1419 Salt Springs Road
Syracuse, NY 13214-1301
315-445-4440 (Health Office)

Dear Nursing Student:

As Nurse Manager of the Wellness Center, I would like to give you some important information related to your **health clearance**, required for the Bachelor of Science degree program in Nursing.

As a Nursing student you are required to take two clinical courses to complete your Bachelor of Science in Nursing degree.

- NSG 410: Management and Leadership in Nursing (22.5 hours of clinical)
- NSG 440: Community Health nursing (45 hours of clinical)

Students in both of these courses will be randomly placed throughout the community to fulfill the clinical requirements. Please pay attention to the following **critical items**:

1. It is **mandatory** to have health clearance prior to the first day of class in-between **May 1st to May 15th .**
2. To comply with these guidelines students must set-up an appointment with the Wellness center to complete your annual health clearance.

We believe that good health is the foundation of a good education. Ideally, all of our students should have a health insurance policy. If you do not currently have health coverage, Le Moyne College offers an Aetna Student Health Insurance policy through Haylor, Freyer, & Coon, Inc. that is reasonably priced. More information on the insurance plan can be found at www.haylor-college.com/lemoyne or by calling 1-800-289-1501.

If you have questions pertaining to the health form or require laboratory titers, see attached form and contact me at 315-445-4440.

The health and safety of our students is very important to us, and compliance with Le Moyne polies helps insure the health of our community. We appreciate your full cooperation with these requirements.

Sincerely,

Cynthia Daniels

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Name: _____
Date of Birth: _____
Social Security: _____

Annual Physical Exam Date _____ Result_____

Health Limitations _____

Tuberculin Skin Test (PPD)
Date given _____Date Read _____ Results: _____
Manufacturer Lot #, Exp. Date _____

Date given_____ Date Read_____ Results: _____
Manufacturer, Lot #, Exp. Date _____

If previous PPD was positive, Date of conversion _____ Reaction_____ mm x ____mm
Chest X-Ray Date: _____
Result:_____

Was treatment taken for positive PPD? _____
Drug _____Date started _____Date completed _____

Rubella Titer: Date:_____ Results: _____
If negative, date of vaccine _____

Rubeola Titer: Date: _____ Results: _____
If negative, dates of vaccine 1. _____2. _____

Mumps Titer: Date _____ Results: _____
If negative, vaccine date: _____

Hepatitis B Vaccine Date: 1. _____2. _____3. _____

Hepatitis B Titer Date: _____Results _____

Print name of Health Care Provider _____ Title _____
Signature of Provider: _____