



Dear Student:

Congratulations! As Nurse Manager of the Wellness Center for Health and Counseling I would like to welcome you as a new member of the Le Moyne Community.

I need to call your attention to the following *critical items*:

- New York State Public Health Law Sections 2165 and 2167 require proof of specific immunizations for all students. In addition, Le Moyne College requires all First Year students to provide proof of a recent physical exam conducted within the past year. The enclosed Immunization and Health Report must be submitted and approved by August 11, 2014.
- If the required Immunization and Health Report is not received by Le Moyne College by August 11, 2014, the student will incur a \$100 non-refundable fine that will be placed on their account. In addition, residential students will not be allowed to move into their residence at the college until this record is received. Lastly, New York State law requires the college to de-register all students who are not in compliance with this regulation, and they will be unable to attend classes.
- The enclosed original *Immunization and Health Report* form must be returned by mail or in person. Please find the postage paid self addressed envelope in the folder pocket of this manual. <u>No faxed copies will be accepted.</u> Copies of the *Immunization and Health Report* can also be found at www.lemoyne.edu/wellness

Insurance Requirement

All full time undergraduate students are *required* to have a health insurance policy, and to carry a current insurance card at all times. Le Moyne College offers a CHP Student Health Insurance policy through Haylor, Freyer & Coon, Inc. that is reasonably priced. The student will be automatically billed for this policy. If the student has other health insurance that will provide medical coverage while residing in Syracuse, the Le Moyne Aetna insurance *charge can be waived*. Instructions for waving the Aetna insurance will be forthcoming with the tuition bill. The waiver process must be completed *by September 15, 2014 for the fall 2014 semester*. 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 general questions regarding the **Health Report**, or our services please contact the Health Services Office at 315-445-4440. If you have questions regarding **immunizations** please contact Cynthia Daniels at 315-445-4442 or danielcm@lemoyne.edu.

The health and safety of our students is very important to us. These medical records provide us with the foundation for good health care during your college career. I appreciate your full cooperation with these requirements.

Sincerely,





FRESHMAN STUDENT IMMUNIZATION AND HEALTH REPORT

This section to be completed by the **Student**

Name:			Gender:	Date of Birth:	
Permanent Address: _			Telepho	one #:	
		# Street			
			Studen	t's Cell #:	
City	State	Zip Code			
Insurance			Policy #	<u> </u>	
Father's Name or Guardian's		Home phone/Cell or work		Occupation	
Mother's Name or Guardian's		Home phone/Cell or work		Occupation	

Health History Requirements

As a new student, you must submit this completed Immunization and Health History form upon admission to the college. This form is the foundation of your medical record at Le Moyne College. This record is reviewed by The Wellness Center for Health and Counseling, and if necessary referred to the College physician for evaluation. It is then filed for reference to be used whenever a consultation for illness or a conference for health appraisal takes place. All information is confidential and will be used only by the Wellness Center for Health and Counseling. You have been accepted to the college, and information you provide on this form will not be used in any way to influence your status at Le Moyne College. It is important that you fully disclose all health and mental health conditions.

If you are enrolling for the fall semester the Immunization and Health Report is due <u>August 12</u>. If you are enrolling for the spring semester the Immunization and Health Report is due January 10. If the Immunization and Health Report is not received by the aforementioned deadlines, the student will incur a <u>\$100 non-refundable</u> fine that will be placed on their account. In addition, residential students will not be allowed to move into their residence at the college until this record is received. Lastly, New York State law requires the college to de-register all students who are not in compliance with this regulation, and they will be unable to attend classes.

This section to be completed by the <u>Student</u>

ALLERGIES: YES NO Drug: Food: Environmental: Specify reaction Do you receive allergy desensitization injections? MEDICAL OR HEALTH CONCERNS — Please check conditions/diseases you have had. Acne Eye injury or Disease Migraines Anemia Fainting Mitral Valve Prolapse Anxiety Fracture (specify) Mononucleosis - Date Arthritis Genetic Disorder Pneumonia/Bronchitis Asthma GERD Pregnancies Attention Deficit Disorder Glaucoma PTSD Back Trouble Heart Murmur Rheumatic Fever Bleeding Disorder Heart Disease Skin Disorder Celiac Disease Hepatitis Stroke Crohn's Disease Herpes/STD Substance Abuse Concussion(s) How many, High/Low Blood Pressure Depression IBS (Irritable Bowel Syndrome) Tumor/Cancer Diabetes Irregular Menstrual Periods Ucer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Drug:					
Specify reaction Do you receive allergy desensitization injections? MEDICAL OR HEALTH CONCERNS — Please check conditions/diseases you have had. Acne Eye injury or Disease Migraines Anemia Fainting Mitral Valve Prolapse Anxiety Fracture (specify) Mononucleosis - Date Arthritis Genetic Disorder Pneumonia/Bronchitis Asthma GERD Pregnancies Attention Deficit Disorder Glaucoma PTSD Back Trouble Heart Murmur Rheumatic Fever Bleeding Disorder Heart Disease Skin Disorder Celiac Disease Hepatitis Stroke Crohn's Disease Hepres/STD Substance Abuse Concussion(s) How many High/Low Blood Pressure Thyroid Disease Depression IBS (Irritable Bowel Syndrome) Tumor/Cancer Diabetes Irregular Menstrual Periods Ulcer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis					
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Celiac Disease Hepatitis Stroke Crohn's Disease Herpes/STD Substance Abuse Concussion(s) How many High/Low Blood Pressure Thyroid Disease Depression IBS (Irritable Bowel Syndrome) Tumor/Cancer Diabetes Irregular Menstrual Periods Ulcer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Crohn's Disease Herpes/STD Substance Abuse Concussion(s) How many High/Low Blood Pressure Thyroid Disease Depression IBS (Irritable Bowel Syndrome) Tumor/Cancer Diabetes Irregular Menstrual Periods Ulcer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Concussion(s) How many High/Low Blood Pressure Thyroid Disease Depression IBS (Irritable Bowel Syndrome) Tumor/Cancer Diabetes Irregular Menstrual Periods Ulcer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Depression IBS (Irritable Bowel Syndrome) Tumor/Cancer Diabetes Irregular Menstrual Periods Ulcer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Diabetes Irregular Menstrual Periods Ulcer Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Eating Disorder Kidney Disease Urinary Tract Infections Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Epilepsy/Seizure Meningitis Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
Do you have an illness or condition, not listed above, for which you are now being treated? (If yes, specify.)					
List any hospitalizations and/or surgeries. (Please provide type and date.)					
Have you had emotional difficulties or other mental health concerns? Describe the diagnosis and treatment (e.g. hospitalizations, psychotherapy and/or medications.)					
Are you currently taking any medication? (Include prescription, over the counter, vitamins/supplements, birth control, herbal medicine.)					
FAMILY HISTORY Name Age Medical Conditions Cause of Death Year of Death					
Name Age Medical Conditions Cause of Death Year of Death Father					
Mother State					
Siblings Siblings					
Children					

Confidentiality Note: The information contained on this form is privileged and confidential and may not be copied or distributed without written permission of the student.





* THIS FORM MUST COMPLETED BY STUDENTS WHO HAVE NOT HAD THE MENINGITIS VACCINE *

MENINGITIS WAIVER RESPONSE FORM

New York State requires that you be informed about meningococcal illness and why it is dangerous. Briefly, it is a bacterial infection that is potentially life-threatening. It often begins with symptoms that can be mistaken for flu, but unlike more common infections it can get worse very rapidly and can cause death in as little as 24 – 48 hours. It can also cause permanent disabilities such as amputations, scarring, hearing loss and brain damage. It is spread from person to person by droplets that are released by coughing or sharing eating utensils, or kissing. While anyone can get this disease, college students living in residence halls are at modestly increased risk for meningitis and may wish to consider vaccination. While the vaccine does not eliminate the risk of meningococcal illness, it is very effective in protecting against 4 of the strains of bacteria including the strain most commonly found on college campuses. More information including our meningitis policy is found on Le Moyne College Health Services website (www.lemoyne.edu/wellness), and can also be found at the CDC website (www.edc.org) or at the American College Health Association website (www.acha.org). You can also speak with your physician regarding this important decision.

New York State Public Health Law requires that <u>all</u> college students complete and return this form to Le Moyne College Health Services. <u>All students</u> must complete this form and have it on file in the Student Health Services office by *August 12*, *2014* for the fall 2014 semester and by *January 13*, *2015* for the 2015 spring semester. Students will be held out of class and will not be able to register for any further classes until compliance is achieved.

Check the statement and sign below.

I have (for students under the age of 18: My child has):

____ read, or have had explained to me, the information regarding meningococcal meningitis. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis.

Signed: _____ Date: _____

(Parent or Guardian if student is a minor)

Print Student's Name: _____

Date of Birth: _____

Last four digits of Student's Social Security Number: _____

MENINGITIS WAIVER RESPONSE FORM (Freshman) 2014-2015

This section to be completed by the <u>Health Care Provider</u>

Student Name:	Date of Birth:
IMMUNIZATIONS (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)
MMR #1// MMR #2/	J OR_ ATTACH LAB RESULT SHOWING IMMUNE STATUS
MENINGOCOCCAL VACCINE (REQUIRED BY STA ENCLOSED MENINGITIS WAIVER RESPONSE FOR	TE LAW) DATE/(CIRCLE MENACTRA <u>OR MENOMUNE) OR SIGN</u> RM.
	IE DATES #1/ #2/ OR _ATTACH LAB RESULT D CERTIFICATE OF DISEASE FROM A PHYSICIAN OR HEALTH DEPARTMENT
HEPATITIS B SERIES (STRONGLEY RECOMMEND	DED) VACCINE DATES #1/ #2/ #3/
TETANUS (ADULT) BOOSTER: (CIRCLE ONE) DTP	TD TDAP DATE:/ (MUST BE UPDATED WITHIN THE PAST 10 YEARS)
Polio Series Completed//	
HPV #1/ #2/ #	3/
Tuberculosis Screening – MUST BE COMPLETED 1. Does the student have signs or symptoms of If No, proceed to 2. If Yes, proceed with addi Tuberculin skin testing, chest X-ray and sputure.	active tuberculosis disease? Yes No tional evaluation to exclude active TB including
2. Is the student a member of a *high-risk grou with skin testing. A history of BCG vaccinatio	p? Yes No If No, stop. If Yes, proceed n does not preclude testing of a high-risk member.
3. Tuberculin Skin Test (Mantoux only and with Date given (month, day, year): Result (in actual mm induration) PPD manufacturer, Lot # and Expiration date:	Date read: (month, day, year)
4. Chest X-ray (required if tuberculin skin test is Results: Normal Tree Tree Tree	positive)
is easier to identify countries of low rather than arrived from countries EXCEPT those on the foll Belgium, Denmark, Finland, France, Germany, Onetherlands, Norway, San Marino, Sweden, Switcategories of high-risk congregate settings such homeless shelters: and those who have clinical	students who have arrived in the past 5 years from countries where TB is endemic. It is high TB prevalence. Therefore, students should undergo TB screening if they have lowing list: Canada, Jamaica, St. Kitts, and Nevis, Saint Lucia, Virgin Islands USA, Greece, Iceland Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, itzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or conditions such as diabetes, chronic renal failure, leukemias, or lymphomas, low ss, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. mmunosuppressive disorders.
PHYSICIAN OR HEALTH CARE PROVIDER (Must	be signed and dated to be acceptable)
PRINTED NAME:	ADDRESS:
SIGNATURE:	PHONE: ()
DATE	

This section to be completed by the <u>Health Care Provider</u>

Student Name:	t Name: Date of Birth:					
PHYSICAL EXAMINATION Date of PE:						
Height: Wei						
Vision: Rt 20/	Lt 20/			Corrected Rt 20/	Lt 20	/
Hearing: Rt						
General Development	Normal	Abnormal	Explanati	ion		
Head/Hair/Scalp						
Skin/Lymphatics						
Eyes						
ENT						
Mouth						
Neck/Thyroid						
Heart						
Lungs/Chest/Breast						
Abdomen (include hernia)						
GU						
Ano-rectal (pilonidal)						
Vascular System						
Neurological						
Musculoskeletal						
Urinalysis: S.G Drug Allergies:						
Current Medications:						
Summary of abnormalities (Please let us know if you h	and/or rec	commendation ncerns, both p	ons, includin	g emotional status.	·	
Is the student able to partic	ipate in all	physical activ	vity? Y	esNo <i>lf</i> "No" what	activities are to be	limited or restricted?
Physician's Signature:						
Physician's Name (Please P						
Office Address:						
	enter for He	alth and Coun	seling at Le N No faxed cop	n and Health Report in its er loyne College, 1419 Salt Spr pies will be accepted	ings Road, Syracuse, I	
				Dato		
Reviewed by: This Immunization				the Le Moyne College Wellr		and Counseling





TO BE COMPLETED BY A PARENT/GUARDIAN ONLY FOR STUDENTS WHO ARE UNDER 18 YEARS OLD AT TIME OF MATRICULATION

CONSENT FOR TREATMENT OF A MINOR AND PERMISSION FOR HEALTH AND COUNSELING

Please complete this form and re	turn it with the other required	d forms.	
Student's Name (please print):			
Date of Birth:			
I hereby give permission to the health daughter (print student name)emotional problems (including injurie		-	, for all physical or
allow me to be reached, or that I can and counselors to secure necessary c indicated treatment.		_	• •
Parent or Guardian Name (plea	se print):		
Signature (parent or guardian): _		Da	te:
PERSON TO NOTIFY IN CASE O	F EMERGENCY		
NAME:		RELATIONSHIP:	
ADDRESS:			
CITY:	STATE:	ZIP:	
HOME PHONE (WITH AREA CODE):			
CELL/BUSINESS PHONE (WITH AREA CO	ODE):		