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 Student:

Welcome! 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 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 ***4 weeks before the start of your classes.***
- If the required ***Immunization and Health Report*** is not received by Le Moyne College 4 weeks before the start of your classes, 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. ***No faxed copies will be accepted.*** 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 an Aetna 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 or February 2, 2015 for the spring 2015 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,

Cynthia Daniels, RN, BSN
Nurse Manager

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# TRANSFER STUDENT IMMUNIZATION AND HEALTH REPORT

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

Name: _____ Gender: _____ Date of Birth: _____

Permanent Address: _____ Telephone #: _____
# Street

_____ Cell phone #: _____
City State Zip Code

Insurance _____ Policy # _____

_____
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 August 11, 2014. If you are enrolling for the spring semester the Immunization and Health Report is due January 12, 2015. If the Immunization and Health Report is not received by the aforementioned deadlines, 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.**

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

**Student Name:** _____ **Date of Birth:** _____

## PERSONAL HEALTH HISTORY

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 | | 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.)
_____

Chronic or long term on-going medical condition? (Please have physician write a medical summary and attach to this form.)
_____

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 |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **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.***

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## ** THIS FORM MUST COMPLETED BY ALL STUDENTS **
## 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.cdc.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 **all** college students complete and return this form to Le Moyne College Health Services. **All students** must complete this form and have it on file in the Student Health Services office by ***August 11, 2014*** for the **fall 2014 semester** and by ***January 12, 2015*** for the **spring 2015 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:

___ 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: _____

***This section to be completed by the Health Care Provider***

**Student Name:** _____ **Date of Birth:** _____

## IMMUNIZATIONS (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)

**MMR** #1____/____/____ **MMR** #2____/____/____ **OR** *ATTACH LAB RESULT SHOWING IMMUNE STATUS*

**MENINGOCOCCAL VACCINE** (REQUIRED BY STATE LAW) DATE____/____/____ (***CIRCLE*** *MENACTRA* **OR** *MENOMUNE) OR SIGN ENCLOSED MENINGITIS WAIVER RESPONSE FORM*.

**VARICELLA VACCINE** (RECOMMENDED) VACCINE DATES #1 ____/____/____ #2____/____/____ **OR** ATTACH LAB RESULT SHOWING IMMUNE STATUS **OR** ATTACH SIGNED CERTIFICATE OF DISEASE FROM A PHYSICIAN OR HEALTH DEPARTMENT

**HEPATITIS B SERIES** (STRONGLEY RECOMMENDED) 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 active tuberculosis disease? Yes____ No____
   If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active TB including Tuberculin skin testing, chest X-ray and sputum evaluation as indicated.

2. Is the student a member of a ***high-risk group?** Yes___ No___ If No, stop. If Yes, proceed with skin testing. A history of BCG vaccination does not preclude testing of a high-risk member.

3. Tuberculin Skin Test (Mantoux only and within past year)
   Date given (month, day, year): _____ Date read: (month, day, year)_____
   Result (in actual mm induration) _____
   PPD manufacturer, Lot # and Expiration date: _____

4. Chest X-ray (required if tuberculin skin test is positive)
   Results: Normal _____ Abnormal _____ Treatment: _____

*Categories of **high risk** students include those students who have arrived in the past 5 years from countries where TB is endemic. It is easier to identify countries of **low** rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries ***EXCEPT*** those on the following list: Canada, Jamaica, St. Kitts, and Nevis, Saint Lucia, Virgin Islands USA, Belgium, Denmark, Finland, France, Germany, Greece, Iceland Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters: and those who have clinical conditions such as diabetes, chronic renal failure, leukemias, or lymphomas, low body weight, gastrectomy and jejunoileal by pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone>15mg/day for >1 month) or other immunosuppressive 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 Health Care Provider***

**Student Name:** _____ **Date of Birth:** _____

**PHYSICAL EXAMINATION**

Date of PE: _____

Height: _____ Weight: _____ BMI: _____ B/P: _____ Pulse: _____

Vision: Rt 20/_____ Lt 20/_____ Corrected Rt 20/_____ Lt 20/_____

Hearing: Rt_____ Lt_____

| **General Development** | Normal | Abnormal | Explanation |
|---|---|---|---|
| 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. _____ Protein _____ Glucose _____

Drug Allergies: _____

Current Medications: _____

**Summary of abnormalities and/or recommendations, including emotional status.**

(Please let us know if you have any concerns, both physical and emotional, about this student, that you would like to share with us.)

_____

_____

_____

Is the student able to participate in all physical activity? ____ Yes ____No ***If*** "No" what activities are to be limited or restricted?

_____

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____

Office Address: _____ Office Phone #: (_____)_____

**Please mail this Immunization and Health Report in its entirety to:**

**Wellness Center for Health and Counseling at Le Moyne College, 1419 Salt Springs Road, Syracuse, NY 13214**

***No faxed copies will be accepted***

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Reviewed by: _____ Date: _____

This Immunization and Health Report will be kept on file at the Le Moyne College Wellness Center for Health and Counseling

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# *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 return it with the other required forms.**

Student's Name (please print): _____

Date of Birth: _____

I hereby give permission to the health and counseling staff at Le Moyne College Wellness Center to treat my son or daughter (print student name) _____, for all physical or emotional problems (including injuries) occurring while he or she is at college. Furthermore, in the event that time will not allow me to be reached, or that I cannot be reached, I hereby give permission for the College Wellness Center physicians and counselors to secure necessary consultative care for my child, to include hospitalization, anesthesia, surgery and other indicated treatment.

Parent or Guardian Name (please print): _____

Signature (parent or guardian): _____ Date: _____

**PERSON TO NOTIFY IN CASE OF EMERGENCY**

**NAME:** _____ **RELATIONSHIP:** _____

**ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**HOME PHONE** (WITH AREA CODE): _____

**Cell/BUSINESS PHONE** (WITH AREA CODE): _____