The Immunization and Health Report is due 3 weeks prior to the start of classes. Students that fail to complete the requirements may incur a $2000 non-refundable fine, a hold on registration and/or a conduct referral. In addition, residential students may 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.

1. Immunization Requirements - minimum NYS requirements include:
   a. **2 MMR** (measles, mumps, rubella) vaccines
   b. **1 meningitis ACWY vaccines** (Menactra or Menveo) within the last 5 years or **2 meningitis B vaccines** (Bexsero or Trumenba) or sign the attached **waiver**.

2. LeMoyne College Immunization Requirement- Completed COVID Vaccine Series

3. Tuberculosis Screening.

4. Physical Exam – recent physical (last high school physical meets this requirement).

5. Health Insurance – the College does not require students to carry a health insurance policy, but we highly recommend that each student have health insurance coverage in order to avoid costly medical expenses while in college. If you are currently uninsured, information about the NY Health Plan Marketplace can be found at [https://info.nystateofhealth.ny.gov/](https://info.nystateofhealth.ny.gov/) or by calling at 315-989-2511, or on our webpage [www.lemoyne.edu/wellness](http://www.lemoyne.edu/wellness)

Congratulations and welcome to Le Moyne College! Additional information can be found on our webpage [www.lemoyne.edu/wellness](http://www.lemoyne.edu/wellness). If you have any questions regarding this information please email us at [healthservices@lemoyne.edu](mailto:healthservices@lemoyne.edu).

The packet can be sent via USPS only or dropped off in person. Mail to:
LeMoyne College – Health Center
1419 Salt Springs Road
Syracuse, NY 13214
First Year Student/Transfer Student
Immunization and Health Report

This section to be completed by the Student

Name: __________________________________________    Gender: _____    Date of Birth: _____________

Permanent Address: ___________________________________ Telephone #: __________________________
# Street

City State Zip Code

Student’s Cell #: __________________________

Insurance __________________________________________ Policy # __________________________

Father’s Name / Guardian     Home phone/Cell #     Work phone #     Occupation

Mother’s Name / Guardian     Home phone/Cell #     Work Phone #     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.

The Immunization and Health Report is due 3 weeks prior to the start of classes. Students that fail to complete the requirements may incur a $2000 non-refundable fine, a hold on registration and/or a conduct referral. In addition, residential students may 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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Conditions</th>
<th>Cause of Death</th>
<th>Year of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Eye Injury or Disease</td>
<td>Migraines</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>Fainting</td>
<td>Mitral Valve Prolapse</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Fracture (specify)</td>
<td>Mononucleosis - Date</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>Genetic Disorder</td>
<td>Pneumonia/Bronchitis</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>GERD</td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>Glaucoma</td>
<td>PTSD</td>
<td></td>
</tr>
<tr>
<td>Back Trouble</td>
<td>Heart Murmur</td>
<td>Rheumatic Fever</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Heart Disease</td>
<td>Skin Disorder</td>
<td></td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>Hepatitis</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>Herpes/STD</td>
<td>Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Concussion(s) How many</td>
<td>High/Low Blood Pressure</td>
<td>Thyroid Disease</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>IBS (Irritable Bowel Syndrome)</td>
<td>Tumor/Cancer</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Irregular Menstrual Periods</td>
<td>Ulcer</td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Kidney Disease</td>
<td>Urinary Tract Infection</td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizure</td>
<td>Meningitis</td>
<td>Ulcerative Colitis</td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Medical Conditions</th>
<th>Cause of Death</th>
<th>Year of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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.*
New York State requires that you be informed about meningococcal disease 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 disease, 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 Student Health Website (www.lemoyne.edu), and can also be found at the CDC website (cdc.gov) and the American College Health Association website (acha.org). You also can speak with your physician regarding this important decision.

New York State Public Health Law requires that all college students have either:

1 dose of meningitis ACWY vaccine within the last 5 years OR
2 meningitis B vaccines OR
decline the vaccine by signing this waiver.

Students that decline the vaccine must complete this form and return it to Le Moyne College Health Services 3 weeks before the start of class. Students may 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 or my son/daughter<18 has:

___ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed: ___________________________ Date: _____________

Student  (Parent/Guardian if student is a minor)

Print Student’s name: ___________________________ Date of Birth: ____________
This section to be completed by the Health Care Provider

Student Name: ___________________________ Date of Birth: ___________________________

IMMUNIZATIONS (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)

REQUIRED:

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

MENINGOCOCCAL VACCINE: (Required by the State within the last 5 years)

CIRCLE ONE: Menactra, Menveo OR Meningitis B OR SIGN ENCLOSED MENINGITIS WAIVER FORM.
#1____/____/____  #2____/____/____

COVID VACCINE:

Modern #1____/____/____  #2____/____/____
Pfizer #1____/____/____  #2____/____/____
Johnson & Johnson (Janssen) #1____/____/____
Other #1____/____/____  #2____/____/____

RECOMMENDED:

VARICELLA VACCINE: VACCINE DATES #1____/____/____  #2____/____/____

HEPATITIS B SERIES: VACCINE DATES #1____/____/____  #2____/____/____  #3____/____/____

TETANUS (ADULT) BOOSTER: (CIRCLE ONE) DTP TD TDAP DATE: ____/____/____  (WITHIN THE PAST 10 YEARS)

HPV #1____/____/____  #2____/____/____  #3____/____/____  REQUIRED:

Tuberculosis Screening

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: ___________ Date read: ___________ 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, leukemia’s, 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: ____________________________

Freshman/Transfer Student
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

Reviewed by: ____________________________________________ Date: ______________
This Immunization and Health Report will be kept on file at the Le Moyne College Wellness Center for Health 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 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): ____________________________