LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT

Wellness Center
for Health and Counseling

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:
   - **2 MMR** (measles, mumps, rubella) vaccines
   - **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. Tuberculosis Screening.
3. Physical Exam – recent physical (recent high school physical meets this requirement).
4. Health Insurance – the College ***does not require*** students to carry 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/ or by calling at 315-989-2511, or on our webpage www.lemoyne.edu/wellness

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

This packet must be uploaded to the patient portal: https://dolphinhealth.lemoyne.edu
Or mailed via USPS:

Le Moyne College
Wellness Center for Health and Counseling
HEALTH SERVICES OFFICE
1419 Salt Springs Road Syracuse, NY 13214
Phone: 315-445-4440

FIRST YEAR NON-NURSING STUDENT
&
TRANSFER STUDENT
IMMUNIZATION AND HEALTH REPORT

This section to be completed by the Student

Name: _____ Gender: _____ Date of Birth: _____

Permanent Address: _____ Telephone #: _____
Street

_____ Student's Cell #: _____
City State Zip Code

Insurance _____ Policy # _____

_____
Father's Name / Guardian Home phone/Cell # Work phone # Occupation

_____
Mother's Name / Guardian Home phone/Cell # Work Phone # Occupation

NCAA Team Member This year? YES____ NO____

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

Today's Date:_____

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 Infection
	Epilepsy/Seizure		Meningitis		Ulcerative Colitis
	Covid-19- Date: _____				

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.)

_____

Do you or 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

Father				
Mother				
Siblings				
Children				
Name	**Age**	**Medical Conditions**	**Cause of Death**	**Year of Death**

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 STUDENTS WHO HAVE NOT HAD THE MENINGITIS VACCINE ***

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 or 3 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: _____

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

THIS SECTION COMPLETED BY HEALTH CARE PROVIDER

REQUIRED:

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

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

CIRCLE ONE: Menactra, Menveo, ACWY, Men B Series **OR** SIGN ENCLOSED MENINGITIS WAIVER FORM.
#1____/____/____ #2____/____/____

RECOMMENDED:

INFLUENZA: VACCINE DATE ____/____/____
COVID BOOSTER: ___/___/___ VACCINE NAME: _____
VARICELLA VACCINE: VACCINE DATES #1 ____/____/____ #2____/____/____
HEPATITIS B SERIES: VACCINE DATES #1____/____/____ #2____/____/____ #3____/____/_____
TETANUS (ADULT) BOOSTER: **TDAP** DATE: ____/____/____ (WITHIN THE PAST 10 YEARS)
HPV #1____/____/____ #2____/____/____ #3____/____/_____
COVID-19 VACCINE:

Moderna #1 ____/____/____ #2____/____/____
Pfizer #1 ____/____/____ #2____/____/____
Johnson & Johnson (Janssen) #1____/____/____
COVID BOOSTER ____/____/____ VACCINE Name_____

TUBERCULOSIS SCREENING QUESTIONNAIRE

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.
   2a) Tuberculin Skin Test (Mantoux only and within past year) ***Only required if high risk or active TB***
   Date given: _____ Date read: _____ Result (in actual mm induration) _____
   PPD manufacturer, Lot # and Expiration date: _____
3. 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:** _____

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

THIS SECTION COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION

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/Supplements:_____

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 of PE: _____

Physician's Name (Please Print): _____

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

No faxed copies will be accepted

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Or mailed via USPS:

Le Moyne College

Wellness Center for Health and Counseling

HEALTH SERVICES OFFICE

1419 Salt Springs Road Syracuse, NY 13214

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Wellness Center

for Health and Counseling

1419 Salt Springs Road Syracuse, NY 13214-1301

315-445-4440 (Health Office)

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): _____