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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Disease/Disorder</th>
<th>Disease/Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Eye injury or Disease</td>
<td>Migraines</td>
</tr>
<tr>
<td>Anemia</td>
<td>Fainting</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Fracture (specify)</td>
<td>Mononucleosis - Date _____________</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Genetic Disorder</td>
<td>Pneumonia/Bronchitis</td>
</tr>
<tr>
<td>Asthma</td>
<td>GERD</td>
<td>Pregnancies</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>Glaucoma</td>
<td>PTSD</td>
</tr>
<tr>
<td>Back Trouble</td>
<td>Heart Murmur</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Heart Disease</td>
<td>Skin Disorder</td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>Hepatitis</td>
<td>Stroke</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>Herpes/STD</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Concussion(s)</td>
<td>High/Low Blood Pressure</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>Depression</td>
<td>IBS (Irritable Bowel Syndrome)</td>
<td>Tumor/Cancer</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Irregular Menstrual Periods</td>
<td>Ulcer</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Kidney Disease</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>Epilepsy/Seizure</td>
<td>Meningitis</td>
<td>Ulcerative Colitis</td>
</tr>
<tr>
<td>Covid-19</td>
<td>Date: ______________</td>
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</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.)

________________________________________________________________________________________________________________________

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**

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Siblings</th>
<th>Children</th>
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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 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: ________________

**Non-Nursing Freshman/Transfer Student May 2023**

**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, Menevo, 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: ___________
**PHYSICAL EXAMINATION**

- **Height:** _____  
- **Weight:** ______  
- **BMI:** ________  
- **B/P:** _______________  
- **Pulse:** _______________

- **Vision:** Rt 20/_______  Lt 20/_________________  Corrected Rt 20/_________________  Lt 20/_________________

- **Hearing:** Rt_________________  Lt_____________

<table>
<thead>
<tr>
<th>General Development</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Explanation</th>
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</thead>
<tbody>
<tr>
<td>Head/Hair/Scalp</td>
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<tr>
<td>Skin/Lymphatics</td>
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<td>Eyes</td>
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<td>ENT</td>
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<td></td>
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<td>Mouth</td>
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<td>Neck/Thyroid</td>
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<td>Heart</td>
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<tr>
<td>Lungs/Chest/Breast</td>
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<tr>
<td>Abdomen (include hernia)</td>
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<td>GU</td>
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<tr>
<td>Ano-rectal (pilonidal)</td>
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<tr>
<td>Vascular System</td>
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<td></td>
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<tr>
<td>Neurological</td>
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<td></td>
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<tr>
<td>Musculoskeletal</td>
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</table>

- **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?**  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

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 #: (_____)___________________**

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*No faxed copies will be accepted*

*This packet must be uploaded to the patient portal: [https://dolphinhealth.lemoyne.edu](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

Non-Nursing Freshman/Transfer Student May 2023
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): __________________________