Dear Health Professions Student:

Congratulations! As Nurse Manager of the Wellness Center I would like to welcome you as a new member of the Le Moyne College Community and give you some important information related to your admission to the Physician Assistant program or Occupational Therapy program or Physical Therapy program or Nursing program.

I would like to call your attention to the following critical items:

- The attached Health & Immunization form must be completed. It is mandatory to provide immunization information, lab work and provide documentation of all lab work.

- Your physical and tuberculosis (TB) testing should be done no earlier than this spring as this documentation is provided to offsite clinical programs.

- Health insurance is required. In the event that you do not have health insurance you can check for eligibility by visiting nysofhealth.gov

Any questions about this information can be directed to the Health Office @ 315-445-4440.

Sincerely,

Nurse Manager
PA / OT/ PT/NURSING
IMMUNIZATION AND HEALTH REPORT

Name: __________________________________________

Date of Birth: ______________________________________

Contact Phone Number: ______________________________

FORM MUST BE RETURNED TO:
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

This report must be completed 6 weeks prior to the start of classes.

All areas must be completed. All lab reports must accompany the packet

You have been accepted to Le Moyne College. The information you provide on this form will not be used to influence your situation at the college. It will be used solely as an aid to provide necessary health care and to allow you to participate at your clinical sites. The information contained in this form is accessible only to the staff of the Wellness Center for Health and Counseling and will not be released without your written authorization or pursuant to a lawfully issued subpoena. The authority to request this information is found in section 355 of the Education Law.
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>
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</thead>
<tbody>
<tr>
<td>Acne</td>
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<tr>
<td>Anemia</td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Attention Deficit Disorder</td>
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<tr>
<td>Back Trouble</td>
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<tr>
<td>Bleeding Disorder</td>
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<tr>
<td>Celiac Disease</td>
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<tr>
<td>Crohn’s Disease</td>
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<tr>
<td>Concussion(s)</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Eating Disorder</td>
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<tr>
<td>Epilepsy/Seizure</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 any taking 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>
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<td></td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Siblings</td>
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<tr>
<td>Children</td>
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</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.
Student name: ___________________________________ DOB: ____________________________

To be completed by your Healthcare Provider – **ALL LAB REPORTS MUST BE ATTACHED**

Immunization & Titer Information **(Titers are required where indicated)**

1. MMR vaccine #1 _____________ MMR vaccine #2 ______________ OR
   Measles (Rubeola) IgG date: __________ results: __________ if negative 2 MMRs are required #1 __________ #2 __________
   Mumps IgG titer date: __________ results: __________ if negative 2 MMRs are required #1 __________ #2 __________
   Rubella IgG titer date: __________ results: __________ if negative 1 MMRs is required #1 __________

2. HEP B #1 _______________ #2 _______________ # 3 _______________ AND

   **Hep B surface antibody IgG titer** (not an antigen test) date: ______________ results: _______________
   if negative Hep B #1 Booster date: __________ titer after 1 month date: __________ results: __________
   if negative Hep B #2 __________ Hep B #3 ______________ titer date: __________ results: __________

3. Varicella vaccine #1 _____________ #2 ______________ OR titer date: __________ results: ______________

4. Flu Vaccine: ___/___/___

5. COVID VACCINE -
   Moderna  #1 ___/___/___ #2 ___/___/___
   Pfizer    #1 ___/___/___ #2 ___/___/___
   Johnson & Johnson (Janssen)  #1 ___/___/___

   Recommended: COVID BOOSTER ___/___/___ VACCINE Name______________________________

Other Immunizations Required

6. Tdap w/in the last 10 years __________________________ (Td does not fulfill this requirement)

7. Meningitis vaccine (ACWY) w/in the last 5 years __________________________ OR
   Men B series #1 ______________ #2 ______________ OR
   Sign the attached meningitis waiver

TB screening - must be within the last 12 months

8. PPD complete all blanks
   Date placed __________ Date read __________ mm of induration ______ Interpretation: Neg or Pos
   Manufacturer __________ lot __________ exp. date __________
   If positive – must supply a negative quantiferon gold or T-spot

OR
   Quantiferon Gold or T-spot date: ______________ results: ______________
   Chest X-ray – required for positive Quantiferon Gold or T-spot Date: ______________ results: ______________
   Treatment for positive TB: ______________ name of medication: __________________
   Date started: ______________ Date completed: __________________ (include documentation)

PHYSICIAN OR HEALTH CARE PROVIDER (Must be signed & dated to be acceptable)

Printed Name: ___________________________________ Address: ____________________________

Signature: ___________________________________ Date: ______________ Phone #: ______________

[Type here] [Type here]
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

<table>
<thead>
<tr>
<th>Head/Hair/Scalp</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin/Lymphatics</td>
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</tr>
<tr>
<td>Eyes</td>
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<tr>
<td>ENT</td>
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<tr>
<td>Mouth</td>
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<td>Neck/Thyroid</td>
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<tr>
<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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<tr>
<td>GU</td>
<td></td>
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</tr>
<tr>
<td>Ano-rectal (pilonidal)</td>
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<tr>
<td>Vascular System</td>
<td></td>
<td></td>
<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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</tr>
</tbody>
</table>

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 upload this Immunization and Health Report in its entirety to the patient portal: https://dolphinhealth.lemoyne.edu

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