LE MOYNE
Greatness meets Goodness

Wellness Center
for Health and Counseling

1419 Salt Springs Road
Syracuse, NY 13214-1301
315-445-4440 (Health Office)

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 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

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PA / OT/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

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 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 any taking 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.

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

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 #: _____

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

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

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 #: (____)_____

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

LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT

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for Health and Counseling

1419 Salt Springs Road Syracuse, NY 13214

315-445-4440 (Health Office)

** THIS FORM MUST COMPLETED BY ALL STUDENTS WHO HAVE NOT HAD A MENINGITIS VACCINE **

MENINGITIS WAIVER RESPONSE FORM

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: _____