Dear OCCUPATIONAL THERAPY 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 OCCUPATIONAL THERAPY program.

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

- As an OT student you will be attending clinical affiliations offsite. It is mandatory to have titers drawn and provide documentation of all lab work.

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

- As we proceed to “go green”, please provide all required health forms and documents in one mailing, due by May 1st for the fall semester.

- You need to provide documentation of recent CPR training.

We believe that good health is the foundation of a good education. Ideally, all of our students should have a health insurance policy. If you do not currently have health coverage, Le Moyne College offers a Student Health Insurance policy through Haylor, Freyer & Coon, Inc. that is reasonably priced. More information on the insurance plan can be found at: www.haylor-college.com/lemoyne or by calling 1-800-289-1501.

If you have questions pertaining to the health forms or required laboratory titers, please contact M. Kathleen Adams, RN at 315-445-4440.

The health and safety of our students is very important to us, and compliance with Le Moyne policies helps insure the health of our community. We appreciate your full cooperation with these requirements.

Sincerely,

M. Kathleen Adams, RN,
Nurse Manager
OCCUPATIONAL THERAPY
IMMUNIZATION AND HEALTH REPORT

Name: __________________________________________

Last Four Digits of Your Social Security Number: ______________________

Contact Phone Number: __________________________

ORIGINAL FORM MUST BE RETURNED TO:

Return to: Le Moyne College
Wellness Center for Health and Counseling
HEALTH SERVICES OFFICE
1419 Salt Springs Road
Syracuse, NY 13214

Phone: 315-445-4440

ALL IMMUNIZATIONS AND PHYSICAL MUST BE COMPLETED BY May 1st for the fall semester.

IT IS VERY IMPORTANT THAT YOU CAREFULLY READ THE ENTIRE IMMUNIZATION PAGE AND PERSONALLY VERIFY THAT ALL THE AREAS ARE COMPLETED. THE IMMUNIZATION PAGE AND THE PHYSICAL PAGE MUST BE SIGNED AND DATED AND ALL AREAS FILLED IN. ALL LAB TESTS MUST BE ACCOMPANIED BY THE LAB REPORT. PLEASE MAKE SURE IT IS ALL COMPLETE BEFORE SENDING THIS HEALTH REPORT TO STUDENT HEALTH SERVICES OFFICE. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CALL OR EMAIL.

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>Acne</th>
<th>Eye injury or Disease</th>
<th>Migraines</th>
</tr>
</thead>
<tbody>
<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>Pneumonia/Bronchitis</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) How many____</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 Infections</td>
</tr>
<tr>
<td>Epilepsy/Seizure</td>
<td></td>
<td>Meningitis</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>
<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.
This section to be completed by the Health Care Provider

Student Name:_____________________________ Date of Birth: ________________

IMMUNIZATIONS (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)

MEASLES (RUBEOLA) TITER DATE: __/__/____ RESULTS: ________________ (attach lab report)

   Negative or equivocal results require 2 vaccinations: DATE: __/__/____
   DATE: __/__/____

RUBELLA TITER RESULTS: ________________ (attach lab report)

   Negative or equivocal results require vaccination: DATE: __/__/____

MUMPS TITER RESULTS: ________________ (attach lab report)

   Negative or equivocal results require vaccination: DATE: __/__/____

VARICELLA TITER DATE: __/__/____ RESULTS: ________________ (attach lab report)

   Negative or equivocal results require 2 vaccinations: DATE: __/__/____
   DATE: __/__/____

HEPATITIS B IMMUNIZATION DATES: #1 __/__/____ #2 __/__/____ #3 __/__/____

HEPATITIS B TITER DATE: __/__/____ RESULTS: ________________ (attach lab report)

   Titer Required. Negative results require repeating the series and then 1 more titer.

MENINGOCOCCAL VACCINE: (Required by the State within the last 5 years) #1 __/__/____ #2 __/__/____

CIRCLE ONE: MENOMUNE, MENACTRA, MEN B OR SIGN ENCLOSED MENINGITIS WAIVER RESPONSE FORM.

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

   (Tdap preferred)

Polio Series Completed: __/__/____

TUBERCULIN SKIN TEST: (Required within 1 year) PPD (Mantoux) Must complete all information.

   Date Given: __/__/____ Product Manufacturer: ____________________________ Lot #/Exp. Date: __/__/____
   Date Read: __/__/____ Results in mm: ____________________________
   If previous PPD was Positive – Date of Conversion: __/__/____

   Chest X-Ray is required for those who are PPD Positive. Date: __/__/____ Result: ____________________________
   Was treatment taken for a positive PPD?: ____________________________
   Drug: ____________________________ Date Started: __/__/____ Date Completed: __/__/____

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

PRINTED NAME: ____________________________ ADDRESS: ____________________________

SIGNATURE: ____________________________ PHONE: (______)____________________

DATE: ____________________________
This section to be completed by the Health Care Provider

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></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/Hair/Scalp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin/Lymphatics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck/Thyroid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs/Chest/Breast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (include hernia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ano-rectal (pilonidal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</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 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
*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 illness 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 illness, 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 Health Services website (www.lemoyn.edu/wellness), and can also be found at the CDC website (www.cdc.org) or at the American College Health Association website (www.acha.org). You can also speak with your physician regarding this important decision.

New York State Public Health Law requires that all college students complete and return this form to Le Moyne College Health Services. All students must complete this form and have it on file in the Student Health Services office by May 1st for the fall semester. Students will 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:

[ ] read, or have had explained to me, the information regarding meningococcal meningitis. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis.

Signed: ___________________________________________ Date: ____________________

(Parent or Guardian if student is a minor)

Print Student’s Name: __________________________________________

Date of Birth: ____________________

Last four digits of Student’s Social Security Number: ____________