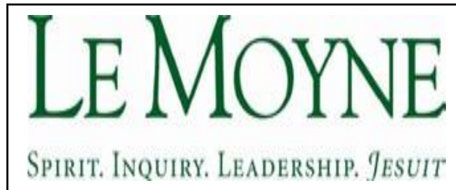

Wellness Center
for Health and Counseling

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.

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. Le Moyne College offers a Student Health Insurance policy through Haylor, Freyer & Coon, Inc. if you do not currently have insurance. More information on the insurance plan can be found at: www.haylor-college.com/lemoyne or by calling 1-800-289-1501**.

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

Sincerely,

M. Kathleen Adams, RN, Nurse
Manager

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

PHYSICIAN ASSISTANT/OCCUPATIONAL THERAPY IMMUNIZATION AND HEALTH REPORT

Name: ____

Date of Birth: ____

Contact Phone Number: __________________________

FORM MUST BE RETURNED TO:

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

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 <u>Student</u>

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.

	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.

Student name: ___________________________________ **DOB**: __________________________

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

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

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__________

HEP B #1_______________ #2________________ # 3________________ **AND**

****Hep B surface antibody IGG titer date: _______ results: _____** if negative repeat the series and titer

#1 __________ #2__________ #3__________ titer date: ___________ results: _____________

Other Immunizations Required

Varicella vaccine #1 ___________________ #2 _______________ **OR** positive titer**:** ______________

Tdap w/in the last 10 years _________________________ **(Td does not fulfill this requirement)**

Meningitis vaccine (ACWY) w/in the last 5 years ______________ **OR**

Men B series #1 ________________ #2 _____________________ **OR** sign the attached waiver

TB screening - must be within the last 12 months

PPD

Date placed __________ Date read ____________ mm of induration _______ Interpretation: Neg or Pos

Manufacturer______________ lot ____________exp. date_________________

OR

Quantiferon Gold or T-spot date: ________________ results:______________________________

Chest xray – required for positive PPD, Quantiferon Gold or T-spot Date: _____________ results: ___________________

Treatment for positive TB: _____________ name of medication: ____________________________

Date started: ________________ Date completed: _______________________

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 <u>Health Care Provider</u>

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	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: ____

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

LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT

Wellness Center
for Health and Counseling

1419 Salt Springs Road
Syracuse, NY 13214-1301
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 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.lemoyne.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 either have one **meningitis ACWY vaccine within the last 5 years or 2 meningitis B** vaccines **or decline the vaccine**. Students that decline the vaccine must complete this form and return it to Le Moyne College Health Services. 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:

___ I 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: ____________________