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/lemoyn](http://www.haylor-college.com/lemoyn) 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
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 Student

Student Name: ___________________________   Date of Birth: ________________

PERSONAL HEALTH HISTORY

ALLERGIES:   YES   NO   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>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Eye injury or Disease</td>
</tr>
<tr>
<td>Anemia</td>
<td>Migraines</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Fainting</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td>Asthma</td>
<td>Fracture (specify)</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>Mononucleosis - Date ________</td>
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<tr>
<td>Back Trouble</td>
<td>Heart Murmur</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>Skin Disorder</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Concussion(s) How many</td>
<td>Herpes/STD</td>
</tr>
<tr>
<td>Depression</td>
<td>High/Low Blood Pressure</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Tobacco/Alcohol</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Tumor/Cancer</td>
</tr>
<tr>
<td>Epilepsy/Seizure</td>
<td>Ulcer</td>
</tr>
<tr>
<td></td>
<td>Kidney Disease</td>
</tr>
<tr>
<td></td>
<td>Urinary Tract Infections</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>
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<tr>
<td>Siblings</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Children</td>
<td></td>
<td></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.
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 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___________

<table>
<thead>
<tr>
<th>General Development</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>
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<tr>
<td>Skin/Lymphatics</td>
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<td></td>
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<tr>
<td>Eyes</td>
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<tr>
<td>ENT</td>
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<td></td>
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<tr>
<td>Mouth</td>
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<td></td>
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<tr>
<td>Neck/Thyroid</td>
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<td></td>
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<tr>
<td>Heart</td>
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<td></td>
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<tr>
<td>Lungs/Chest/Breast</td>
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<td></td>
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<tr>
<td>Abdomen (include hernia)</td>
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<tr>
<td>GU</td>
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<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>
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<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
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<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 Phone #: (____) __________________________

Office Address: __________________________________________

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
* THIS FORM MUST BE 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: _____________________________