

LE MOYNE

SPIRIT. INQUIRY. LEADERSHIP. *JESUIT.*



Phone (315) 445-4440 Fax (315) 445-4714

IMMUNIZATION AND HEALTH REPORT

This portion is to be completed by the student.

Name _____ Gender _____ Date of Birth _____

Address _____ Telephone No. _____

Street

_____ Cell phone No. _____

City _____ State _____ Zip code _____

Insurance _____ Policy # _____

Father's Name or Guardian's _____ Home phone/Cell or work _____ Occupation _____

Mother's Name or Guardian's _____ Home phone/Cell or work _____ Occupation _____

Consent

I HEREBY GIVE CONSENT FOR MY **MINOR CHILD <18** or **SELF (circle one)** TO RECEIVE ROUTINE CARE THROUGH THE WELLNESS CENTER FOR HEALTH AND COUNSELING AT LE MOYNE COLLEGE.

Signature of Parent or Guardian _____ Date _____ Signature of Student _____ Date _____

Health History Requirements

As a new student, you must submit a completed health history and immunization form upon admission to the college. The form is the foundation of your medical record at Le Moyne College. This record is reviewed by The Wellness Center for Health and Counseling, and if necessary referred to the College physician for evaluation. It is then filed for reference to be used whenever a consultation for illness or a conference for health appraisal takes place. **All information is confidential and will be used only by the Wellness Center for Health and Counseling.** You have been accepted and information you provide on this form will not be used to influence your status at Le Moyne College. Before your registration is considered final, the appropriate sections of this form must be completed by you and your clinician and mailed to the Wellness Center.

If you are enrolling for the fall semester the Immunization and Health Report is due August 10. If you are enrolling for the spring semester the Immunization and Health Report is due January 10. If the Immunization and Health Report is not received by the aforementioned deadlines, the student will incur a \$100 non-refundable fine that will be placed on their account. In addition, residential students will not be allowed to move into their residence at the college until this record is received. Lastly, New York State law requires the college to de-register all students who are not in compliance with this regulation, and they will be unable to attend classes.

This section to be completed by Healthcare Provider

Name _____ Date of Birth _____

IMMUNIZATIONS (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)

MMR #1 ___/___/___ MMR #2 ___/___/___ **OR** ATTACH LAB RESULT SHOWING IMMUNE STATUS

MENINGOCOCCAL VACCINE (REQUIRED BY STATE LAW) DATE ___/___/___ (**CIRCLE** MENACTRA **OR** MENOMUNE) WAIVER ON FOLLOWING PAGE MAY BE SUBSTITUTED.

VARICELLA VACCINE (REQUIRED BY STATE LAW) VACCINE DATES #1 ___/___/___ #2 ___/___/___ **OR** ATTACH LAB RESULT SHOWING IMMUNE STATUS **OR** ATTACH SIGNED CERTIFICATE OF DISEASE FROM A PHYSICIAN OR HEALTH DEPARTMENT

HEPATITIS B SERIES (STRONGLY RECOMMENDED) VACCINE DATES #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

TETANUS (ADULT) BOOSTER: (**CIRCLE ONE**) DTP TD TDAP DATE: ___/___/___ (UPDATED WITHIN THE PAST 10 YEARS)

Polio Series Completed ___/___/___

HPV #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Tuberculosis Screening – MUST BE COMPLETED

1. Does the student have signs or symptoms of active tuberculosis disease? Yes ___ No ___

If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active TB including Tuberculin skin testing, chest X-ray and sputum evaluation as indicated.

2. Is the student a member of a ***high-risk group**? Yes ___ No ___ If No, stop. If Yes, proceed

with skin testing. A history of BCG vaccination does not preclude testing of a high-risk member.

3. Tuberculin Skin Test (Mantoux only and within past year)

Date given (month, day, year): _____ Date read: (month, day, year) _____

Result (in actual mm induration) _____

PPD manufacturer, Lot # and Expiration date: _____

4. Chest X-ray (required if tuberculin skin test is positive)

Results: Normal ___ Abnormal ___ Treatment: _____

*Categories of **high risk** students include those students who have arrived in the past 5 years from countries where TB is endemic. It is easier to identify countries of **low** rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries **EXCEPT** those on the following list: Canada, Jamaica, St. Kitts, and Nevis, Saint Lucia, Virgin Islands USA, Belgium, Denmark, Finland, France, Germany, Greece, Iceland Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters: and those who have clinical conditions such as diabetes, chronic renal failure, leukemias, or lymphomas, low body weight, gastrectomy and jejunoileal by pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone>15mg/day for >1 month) or other immunosuppressive disorders.

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 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
Chron'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 or psychological problems? Describe the treatment (e.g. hospitalizations, psychotherapy and/or medications.)

Are you currently 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 page to be completed by Healthcare Provider

PHYSICAL EXAMINATION

Date of PE _____

Student's Name _____ Date of Birth _____

Height _____ Weight _____ BMI _____ B/P _____ Pulse _____

Vision: Rt 20/ _____ Lt 20/ _____ Corrected Rt 20/ _____ Lt 20/ _____

Hearing: Rt _____ Lt _____

General Development Normal Abnormal Explanation

General Development	Normal	Abnormal	Explanation
Head/Hair/Scalp			
Skin/Lymphatic's			
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
No faxed or emailed 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



MENINGITIS 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 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 **August 10** for the fall semester and by **January 10** for the spring semester. Students will be held out of class and will not be able to register for any further classes until compliance is achieved.

Check one statement and sign below.

I have (for students under the age of 18: My child has):

___ had the meningitis vaccine (meningococcal polysaccharide sero-groups A/C/Y/W135) within the past 10 years **and I am providing the documentation, from a doctor or school.**

___ 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: _____