Health Office requirements are due 3 weeks prior to the start of class – failure to submit these requirements may result in fines up to $2000, a hold on registration and a conduct referral.

1. Immunization Requirements - minimum NYS requirements include:
   a. **2 MMR** (measles, mumps, rubella) vaccines
   b. **1 meningitis ACWY vaccines** (Menactra or Menevo) within the last 5 years or **2 meningitis B vaccines** (Bexsero or Trumenba) or sign the attached waiver.
2. Tuberculosis Screening.
3. Physical Exam – recent physical (last high school physical meets this requirement).
4. Insurance – students will automatically be billed for student health insurance, but it can be waived if the student has private insurance (instructions will be emailed to the student on how to waive insurance).

Congratulations and welcome to Le Moyne College. Additional information can be found on our webpage [www.lemoyne.edu/wellness](http://www.lemoyne.edu/wellness). If you have any questions regarding this information please call the Wellness Center for Health and Counseling @ 315-445-4440 or email us at [healthservices@lemoyne.edu](mailto:healthservices@lemoyne.edu).

The packet may be dropped off at the Health Center or mailed to:
Le Moyne College – Health Center
1419 Salt Springs Road
Syracuse, NY 13214
FRESHMAN STUDENT/TRANSFER STUDENT
IMMUNIZATION AND HEALTH REPORT

This section to be completed by the Student

Name: ___________________________________________ Gender: _____ Date of Birth: ________________

Permanent Address: ___________________________________ Telephone #: ________________

# Street

City State Zip Code

Student’s Cell #: ________________

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

Health History Requirements

As a new student, you must submit this completed Immunization and Health History form upon admission to the college. This 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 to the college, and information you provide on this form will not be used in any way to influence your status at Le Moyne College. It is important that you fully disclose all health and mental health conditions.

The Immunization and Health Report is due 3 weeks prior to the start of classes. Students that fail to complete the requirements may incur a $2000 non-refundable fine, a hold on registration and/or a conduct referral. In addition, residential students may 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.

Freshman/Transfer 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>Condition</th>
<th>Medical Conditions</th>
<th>Cause of Death</th>
<th>Year of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Eye Injury or Disease</td>
<td>Migraines</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>Fainting</td>
<td>Mitral Valve Prolapse</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Fracture (specify)</td>
<td>Mononucleosis - Date__________</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>Genetic Disorder</td>
<td>Pneumonia/Bronchitis</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>GERD</td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>Glaucoma</td>
<td>PTSD</td>
<td></td>
</tr>
<tr>
<td>Back Trouble</td>
<td>Heart Murmur</td>
<td>Rheumatic Fever</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Heart Disease</td>
<td>Skin Disorder</td>
<td></td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>Hepatitis</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>Herpes/STD</td>
<td>Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Concussion(s) How many___</td>
<td>High/Low Blood Pressure</td>
<td>Thyroid Disease</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>IBS (Irritable Bowel Syndrome)</td>
<td>Tumor/Cancer</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Irregular Menstrual Periods</td>
<td>Ulcer</td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Kidney Disease</td>
<td>Urinary Tract Infection</td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizure</td>
<td>Meningitis</td>
<td>Ulcerative Colitis</td>
<td></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 taking any 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>
</tbody>
</table>

| 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.
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 the meningitis ACWY vaccine within the last 5 years or have Meningitis B vaccine series. Student who 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 (for students under the age of 18: My child has):

____ 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: ____________
Student Name: ___________________________________ Date of Birth: ____________________

IMMUNIZATIONS (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)

REQUIRED:

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

MENINGOCOCCAL VACCINE: (Required by the State within in the last 5 years)

CIRCLE ONE: Menactra, Menveo OR Meningitis B OR SIGN ENCLOSED MENINGITIS WAIVER FORM.  
#1___/___/____  #2___/___/____

RECOMMENDED:

VARICELLA VACCINE: VACCINE DATES #1___/___/____ #2___/___/____

HEPATITIS B SERIES: VACCINE DATES #1___/___/____ #2___/___/____ #3___/___/____

TETANUS (ADULT) BOOSTER: (CIRCLE ONE) DTP TD TDAP DATE: ___/___/____ (WITHIN THE PAST 10 YEARS)  
HPV #1___/___/____ #2___/___/____ #3___/___/____

REQUIRED:

Tuberculosis Screening

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: ___________ Date read: ___________ 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, leukemia’s, 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 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>
</tr>
<tr>
<td>Skin/Lymphatics</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Eyes</td>
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<td></td>
<td></td>
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<tr>
<td>ENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Neck/Thyroid</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lungs/Chest/Breast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (include hernia)</td>
<td></td>
<td></td>
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<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>
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<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

Freshman/Transfer Student
*TO BE COMPLETED BY A PARENT/GUARDIAN 
ONLY FOR STUDENTS WHO ARE UNDER 
18 YEARS OLD AT TIME OF MATRICULATION*

CONSENT FOR TREATMENT OF A MINOR AND PERMISSION FOR HEALTH AND COUNSELING

Please complete this form and return it with the other required forms.

Student’s Name (please print): _____________________________________________

Date of Birth: ______________________

I hereby give permission to the health and counseling staff at Le Moyne College Wellness Center to treat my son or daughter (print student name) ____________________________________________, for all physical or emotional problems (including injuries) occurring while he or she is at college. Furthermore, in the event that time will not allow me to be reached, or that I cannot be reached, I hereby give permission for the College Wellness Center physicians and counselors to secure necessary consultative care for my child, to include hospitalization, anesthesia, surgery and other indicated treatment.

Parent or Guardian Name (please print): _______________________________________________________

Signature (parent or guardian): ______________________________________ Date: ______________

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: ___________________________________________ RELATIONSHIP: ___________________

ADDRESS: ____________________________________________________________________________

CITY: ___________________________ STATE: _________________ ZIP: ________________________

HOME PHONE (WITH AREA CODE): __________________________

CELL/BUSINESS PHONE (WITH AREA CODE): __________________________

Freshman/Transfer Student