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. In the event that you do not have health insurance you can check for eligibility by visiting [nysofhealth](http://nysofhealth)

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

Sincerely,

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

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>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Eye Injury or Disease</td>
<td>Migraines</td>
</tr>
<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>Pregnancies</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 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>
</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>Meningitis</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 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>
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<tr>
<td>Siblings</td>
<td></td>
<td></td>
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<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.
Student name: ________________________________ DOB: ________________________________

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

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

1. 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 MMR is required #1 __________

2. HEP B #1 ______________ #2 ______________ # 3 ______________ AND
   - **Hep B surface antibody IgG titer** (not an antigen test) date: __________ results: __________
     - if negative  Hep B #1 Booster date: __________ titer after 1 month date: __________ results: __________
     - if negative  Hep B #2 __________ Hep B #3 __________ titer date: __________ results: __________

3. Varicella vaccine #1 ___________ #2 ___________ OR  titer date: __________ results: __________

Other Immunizations Required
4. Tdap w/in the last 10 years _________________ (Td does not fulfill this requirement)
5. Meningitis vaccine (ACWY) w/in the last 5 years _________________ OR
   - Men B series #1 ____________ #2 _________________ OR
   - Sign the attached meningitis waiver

Other Immunizations Recommended
6. COVID VACCINE -
   - Moderna  #1 __/__/____  #2 __/__/____
   - Pfizer  #1 __/__/____  #2 __/__/____
   - Johnson & Johnson (Janssen)  #1 __/__/____
   - Other  #1 __/__/____  #2 __/__/____

TB screening - must be within the last 12 months
7. PPD complete all blanks
   - Date placed __________ Date read __________ mm of induration ______ Interpretation: Neg or Pos
   - Manufacturer __________ lot __________ exp. date __________
     - If positive – must supply a negative quantiferon gold or T-spot

OR
- Quantiferon Gold or T-spot  date: ____________ results: ____________
   - Chest X-ray – required for positive Quantiferon Gold or T-spot Date: ____________ results: ____________
   - Treatment for positive TB: ____________ name of medication: ____________
   - Date started: ____________ Date completed: ____________ (include documentation)

PHYSICIAN OR HEALTH CARE PROVIDER (Must be signed & dated to be acceptable)
Printed Name: ________________________________ Address: ________________________________
Signature: ________________________________ Date: ____________ Phone #: ______________________

PA titer & immunization report 3/21
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>
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<td></td>
<td></td>
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<tr>
<td>Skin/Lymphatics</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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<tr>
<td>Neck/Thyroid</td>
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<tr>
<td>Heart</td>
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<tr>
<td>Lungs/Chest/Breast</td>
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<tr>
<td>Abdomen (include hernia)</td>
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<td>GU</td>
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<tr>
<td>Ano-rectal (pilonidal)</td>
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<tr>
<td>Vascular System</td>
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<td></td>
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<tr>
<td>Neurological</td>
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<tr>
<td>Musculoskeletal</td>
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</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
MENINGITIS WAIVER RESPONSE FORM

New York State requires that all college students have either:

1 dose of meningitis ACWY vaccine within the last 5 years OR
2 meningitis B vaccines OR
decline the vaccine by signing this waiver.

Students that decline the vaccine must complete this form and return it to Le Moyne College Health Services 3 weeks before the start of class. Students may 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 or my son/daughter<18 has:

___ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed: ___________________________________________ Date: ____________

Student  (Parent/Guardian if student is a minor)

Print Student’s name: ___________________________________ Date of Birth: ____________