GRADUATE/NON-DEGREE STUDENTS
COMPLETING AND RETURNING THIS FORM ARE REQUIREMENTS FOR ADMISSION

Student Name (please print) ____________________________________ BU ID No. _____________

Admitted as a (check one): _____ Graduate _____ Non-Degree

Session (check one): _____ Fall _____Spring _____ Summer

TUBERCULOSIS: A requirement for admission is the date and result of a Mantoux Tuberculin Skin Test done within one (1) year of your matriculation to Bucknell regardless of previous BCG inoculation. Persons currently known to be positive reactors need not be retested, but must provide the results of a chest x-ray done within one (1) year of matriculation. Reaction of 5–14 mm should be evaluated based on the CDC's recommendations.

	Test Date	Result
Mantoux Tuberculin Skin Test and result within one (1) year	__________	_________mm
If tuberculin test is positive:		
Chest x-ray must be done to rule out active TB	__________	__________
and, optional **Quantiferon Gold test** may be done.	__________	__________

If chest x-ray or Quantiferon Gold test is positive,
proof of **INH (Isoniazid) treatment** is required. Treatment dates from: _________ to __________

TDAP (Tetanus, Diphtheria and Pertussis) vaccine within the past 10 years. Vaccine date __________

Date ________________ Nurse/Physician's Name ____
(please print)

Nurse/Physician's Signature____

Address____
(Street City State Zip Country)

Telephone: (______) ________________________________

MENINGITIS – Please check the statement that applies and sign:

_____ I have received the meningitis vaccine within the past three years. Vaccine date _______________.

_____ I have read and understand the information about meningitis, and I decline the meningitis vaccine or meningitis booster vaccine at this time. I understand that if I decide in the future that I want the vaccine, I can receive it at the Student Health Service and that I am responsible for the cost.

Student's signature (or Parent's signature if student is under 18) Student's printed name Date

I verify that all the above information is correct and that I have reviewed a copy of the Notice of Privacy Practices for the Bucknell University Student Health Service (www.bucknell.edu/X7910.xml)

Student Signature ____ Date _______________

Parent Signature if student is under age 18 ______________________________ Date _______________

Please complete this form and return it to:

The Medical Director, Student Health Service, Bucknell University, Lewisburg, PA 17837

Telephone: 570.577.1401 Fax: 570.577.3570