

This form must be completed in English in its entirety and sent to the Medical Director, Bucknell University, Lewisburg, PA 17837 not later than June 15 for fall enrollment or January 3 for spring enrollment. Failure to comply will prevent student from registering.

During the summer months, inquiries regarding the medical record are received weekdays from 8:30-11:30 a.m. at 570-577-1401. The office is closed during the afternoons.

Parts I & II to be completed and signed by student  
Parts III, IV, V to be completed and signed by physician

**PART I – DEMOGRAPHICS**

Year of entrance \_\_\_\_\_ Admitted as a  First-Year  Transfer  Graduate  Special BU ID# \_\_\_\_\_

PLEASE PRINT NAME LEGIBLY IN INK Student's Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

1. FULL NAME OF STUDENT \_\_\_\_\_  
Last Name First Name Middle Name

2. HOME ADDRESS \_\_\_\_\_  
Street City State Zip

3 TELEPHONE: HOME ( \_\_\_\_\_ ) \_\_\_\_\_ Mother's Employment ( \_\_\_\_\_ ) \_\_\_\_\_  
Father's Employment ( \_\_\_\_\_ ) \_\_\_\_\_

4. AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ COUNTRY OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

5. EMERGENCY NOTIFICATION. In case of serious illness or accident, notify (parents or other):  
Relationship \_\_\_\_\_  
Full name(s) \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
Street City State Zip

Telephone (if different from above): ( \_\_\_\_\_ ) \_\_\_\_\_

6. FAMILY HISTORY

**PART II – MEDICAL HISTORY**

	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH	HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING	NO	YES	RELATIONSHIP
Father						Alcoholism			
Mother						Cancer			
Brothers						Depression			
						Diabetes			
Sisters						Heart Disease, Hypertension			
						Seizure Disorder			
						Suicide			
						Tuberculosis			

7. PERSONAL HISTORY – Please answer all questions. Comment on all positive answers in the space below.

HAVE YOU HAD?	No	Yes	HAVE YOU HAD?	No	Yes	HAVE YOU HAD?	No	Yes	HAVE YOU HAD?	No	Yes
Anxiety			Eating Disorders			Jaundice			Tuberculosis (Pos. PPD)		
Asthma			Eye Trouble			Leukemia or Lymphoma			Tumor, Cancer		
Back Problems			Gallstones/Gallbladder Disease			Malaria			Urinary Tract Problems		
Broken Bones			Gastrointestinal Disorder			Pain /Pressure in Chest			Used an Inhalor		
Chronic Cough			Hay Fever			Palpitations (Heart)			Weakness, Paralysis		
Depression			Head Injury w/Unconsciousness			Recent Weight Gain/Loss (10+ lbs)			Wisdom Teeth Extraction		
Diabetes			Heart Murmur			Recurrent Headaches			Other		
Dizziness, Fainting			High or Low Blood Pressure			Rheumatic Fever					
Ear, Nose, Throat Trouble			Insomnia			Shortness of Breath					

	No	Yes (Specify)	Remarks or additional information (use additional sheet if necessary)
Are you currently taking any medication?			
Are you presently being treated for any condition?			
Do you have any known allergies: drug?			
food?			
other?			
Have you ever received treatment for any psychiatric, mental health, or psychological condition? Explain.			
Have you had any surgical procedures? Explain.			
Have you had any illness or injury or been hospitalized other than already noted? Explain.			

Act 10 of the General Assembly of the Commonwealth of Pennsylvania was approved February 13, 1970, stating: Any minor who is eighteen years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental, or health services for himself or herself, and the consent of no other shall be necessary.

The above information is true to the best of my knowledge.

I acknowledge that I have received a copy of the Notice of Privacy Practices for the Bucknell University Student Health Service (enclosed).

DATE \_\_\_\_\_ STUDENT'S SIGNATURE \_\_\_\_\_

### PART III – PHYSICAL EXAMINATION

*Physical examination acceptable only if done within one (1) year prior to matriculation at Bucknell*

To the examining physician: Please review the student's history and complete Parts III, IV and V. Please comment on all positive answers.

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex \_\_\_\_\_

**BP** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Respiration** \_\_\_\_\_ **Temperature** \_\_\_\_\_

**Vision** without lenses: R. 20/\_\_\_\_\_ L. 20/\_\_\_\_\_ both \_\_\_\_\_ with lenses: R. 20/\_\_\_\_\_ L. 20/\_\_\_\_\_ both \_\_\_\_\_

**Urinalysis:** Albumin \_\_\_\_\_ Sugar \_\_\_\_\_

**Allergies to medication**

Are there abnormalities of the following systems? Describe fully.

	No	Yes	Comments (Use additional sheet if needed)
1. Head, Eyes, Ears, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neurologic			
10. Skin			

Is there loss or seriously impaired function of any paired organ? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_

Recommendations for physical activity: Unlimited \_\_\_\_\_ Limited \_\_\_\_\_ Explain: \_\_\_\_\_

Has the patient ever been diagnosed for any psychiatric or mental health condition? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain \_\_\_\_\_

Is there a history of eating disorders? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_

Do you have any recommendations regarding the care of this student? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_

How long have you known this student? \_\_\_\_\_ General comments: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Please measure student's height and weight today, then locate patient's height on chart below and circle weight range to the right of that height.

#### MEN

HEIGHT	WEIGHT RANGES
5' 1"	= or < 123 lbs    124-145    = or > 146
5' 2"	= or < 125 lbs    126-148    = or > 149
5' 3"	= or < 127 lbs    128-151    = or > 152
5' 4"	= or < 129 lbs    130-155    = or > 156
5' 5"	= or < 131 lbs    132-159    = or > 160
5' 6"	= or < 133 lbs    134-163    = or > 164
5' 7"	= or < 135 lbs    136-167    = or > 168
5' 8"	= or < 137 lbs    138-171    = or > 172
5' 9"	= or < 139 lbs    140-175    = or > 176
5' 10"	= or < 141 lbs    142-179    = or > 180
5' 11"	= or < 144 lbs    145-183    = or > 184
6' 0"	= or < 147 lbs    148-187    = or > 188
6' 1"	= or < 150 lbs    151-192    = or > 193
6' 2"	= or < 153 lbs    154-197    = or > 198
6' 3"	= or < 157 lbs    158-202    = or > 203
6' 4"	= or < 160 lbs    161-207    = or > 208
6' 5"	= or < 163 lbs    164-212    = or > 213
6' 6"	= or < 166 lbs    167-217    = or > 218
6' 7"	= or < 169 lbs    170-222    = or > 223
6' 8"	= or < 172 lbs    173-226    = or > 227
6' 9"	= or < 175 lbs    176-232    = or > 233
6' 10"	= or < 178 lbs    179-237    = or > 238
6' 11"	= or < 181 lbs    182-242    = or > 243

#### WOMEN

HEIGHT	WEIGHT RANGES
4' 9"	= or < 90 lbs    91-129    = or > 130
4' 10"	= or < 92 lbs    93-130    = or > 131
4' 11"	= or < 94 lbs    95-135    = or > 136
5' 0"	= or < 96 lbs    97-137    = or > 138
5' 1"	= or < 99 lbs    100-140    = or > 141
5' 2"	= or < 102 lbs    103-144    = or > 145
5' 3"	= or < 105 lbs    106-148    = or > 149
5' 4"	= or < 108 lbs    109-152    = or > 153
5' 5"	= or < 111 lbs    112-156    = or > 157
5' 6"	= or < 114 lbs    115-160    = or > 161
5' 7"	= or < 118 lbs    119-164    = or > 165
5' 8"	= or < 122 lbs    123-167    = or > 168
5' 9"	= or < 126 lbs    127-170    = or > 171
5' 10"	= or < 130 lbs    131-173    = or > 174
5' 11"	= or < 134 lbs    135-176    = or > 177
6' 0"	= or < 138 lbs    139-179    = or > 180
6' 1"	= or < 142 lbs    143-183    = or > 184
6' 2"	= or < 146 lbs    147-187    = or > 188

## PART IV – IMMUNIZATION RECORD

If the immunization requirements are not met, the student will **not** be permitted to register. **Please record dates (month/day/year) below – DO NOT enclose immunization sheet.**

Name \_\_\_\_\_  
Last
First
Middle

**REQUIRED:**

1. **Tetanus/Diphtheria (TD) or Tetanus/Diphtheria/Pertussis (Tdap) Booster** within the last 10 years TD Date \_\_\_/\_\_\_/\_\_\_  
OR Tdap Date \_\_\_/\_\_\_/\_\_\_

2, 3, 4. **MMR (Measles/Mumps/Rubella)**  
 Two (2) doses after age 12 months, at least 28 days apart, and since 1981. 1st Dose Date \_\_\_/\_\_\_/\_\_\_ 2nd Dose Date \_\_\_/\_\_\_/\_\_\_  
 Blood test reports indicating immunity are acceptable.

**OR** If these immunizations were given separately instead of together, complete 2, 3, 4 below:

2. **Measles:** Rubeola (7-10 day variety) 1st Dose Date \_\_\_/\_\_\_/\_\_\_ 2nd Dose Date \_\_\_/\_\_\_/\_\_\_

3. **Mumps** 1st Dose Date \_\_\_/\_\_\_/\_\_\_ 2nd Dose Date \_\_\_/\_\_\_/\_\_\_

4. **Rubella:** German or 3-day Measles 1st Dose Date \_\_\_/\_\_\_/\_\_\_ 2nd Dose Date \_\_\_/\_\_\_/\_\_\_

5. **Polio (OPV or IPV):** Basic series and last booster (at least one [1] year following completion of basic series) required. Basic Series Dates \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_  
Last Booster Date \_\_\_/\_\_\_/\_\_\_

6. **Mantoux Tuberculin Skin Test (TST) is REQUIRED** within one (1) year prior to matriculation at Bucknell regardless of previous BCG inoculation (tine or monovac not acceptable). **Date and result required.**  
 Result should be based on mm of induration and Interpretation Guidelines\*\* below. TST Date \_\_\_/\_\_\_/\_\_\_ Result\*\* \_\_\_ mm  
**For previous positive TST, record date and result of test, and treatment information below.**

**\*\*INTERPRETATION GUIDELINES**

**> 5 mm is positive:**

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for >1 month; taking a TNF- $\alpha$  antagonist
- Persons with HIV/AIDS

**> 10 mm is positive:**

- Persons born in a high prevalence country or who resided in one for a significant amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

**> 15 mm is positive:**

- Persons with no known risk factors for TB disease

**If the TST result is positive:**

a) Chest X-Ray required Date \_\_\_/\_\_\_/\_\_\_ Result: Normal \_\_\_ Abnormal \_\_\_

**AND**

b) Treatment recommended Date Started \_\_\_/\_\_\_/\_\_\_ Date Ended \_\_\_/\_\_\_/\_\_\_

7. **Hepatitis B**  
 A 3-shot series is required. First of 3 must have been given prior to enrollment at Bucknell. A blood test report showing immunity is acceptable. Series must be completed within one (1) year. 1st Dose \_\_\_/\_\_\_/\_\_\_ 2nd Dose \_\_\_/\_\_\_/\_\_\_ 3rd Dose \_\_\_/\_\_\_/\_\_\_

8. **Meningitis (Meningococcal vaccine — A, C, Y, W-135)** Date \_\_\_/\_\_\_/\_\_\_

**Vaccine date or signature (below) declining vaccine required.**

(Please read Meningitis information on enclosed yellow Directions/Meningitis Information sheet).

**OR**

**WAIVER:** I read and understand the meningitis information provided and I decline the meningitis vaccine at this time.

\_\_\_\_\_  
 Student's Signature

\_\_\_\_\_  
 Parent's Signature if student is under age 18.

9. **Chicken Pox: Varicella**  
 History of having the disease, vaccine, or blood test report indicating immunity by providing laboratory report is acceptable.  
 History of disease Date \_\_\_/\_\_\_/\_\_\_  
**OR** Two doses required. 1st Dose Date \_\_\_/\_\_\_/\_\_\_ 2nd Dose Date \_\_\_/\_\_\_/\_\_\_

**OTHER IMMUNIZATIONS RECEIVED (not required):**

1. **HPV (Human Papillomavirus Vaccine)** 1st Dose \_\_\_/\_\_\_/\_\_\_ 2nd Dose \_\_\_/\_\_\_/\_\_\_ 3rd Dose \_\_\_/\_\_\_/\_\_\_

2. **Hepatitis A** 1st Dose Date \_\_\_/\_\_\_/\_\_\_ 2nd Dose Date \_\_\_/\_\_\_/\_\_\_

3. \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_ Type 4. \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_ Type

**PART V**

Name \_\_\_\_\_  
Last First Middle

Please complete the following:

**CAGE**  
When honestly answered, the following four-item questionnaire known as CAGE has become recognized as one of the most efficient and effective alcohol dependency screening devices.

1. Have you ever felt you should  
**C**ut down on your drinking? No \_\_\_\_\_ Yes \_\_\_\_\_

2. Have people  
**A**nnoyed you by criticizing your drinking? No \_\_\_\_\_ Yes \_\_\_\_\_

3. Have you ever felt bad or  
**G**uilty about your drinking? No \_\_\_\_\_ Yes \_\_\_\_\_

4. Have you ever had a drink first thing  
in the morning to steady nerves  
or to get rid of a hangover?  
**E**ye-opener No \_\_\_\_\_ Yes \_\_\_\_\_

**TOBACCO USAGE** (Check one in each category)

	Never	Rare	Occasional	Regular
Cigarettes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuff		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the information provided on PARTS III, IV and V of this form is true and complete.

Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_, M.D./ D.O.

Address \_\_\_\_\_  
Street

City State Zip

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

For Physician's Stamp