This form must be printed, completed in English in its entirety and the original sent to:

Bucknell Student Health
One Dent Drive
Bucknell University
Lewisburg, PA 17837

No later than June 15 for fall enrollment or January 3 for spring enrollment. Failure to comply will prevent students from obtaining a dorm room key upon arrival.

Please keep a copy of this completed form for your records.

All VARSITY ATHLETES will be sent an additional ATHLETIC MEDICAL FORM that also must be completed and returned to the ATHLETIC DEPARTMENT.

All DOMESTIC STUDENTS are required to enroll or waive the Bucknell Student Health Insurance plan online. This form is not a waiver. Postcards will be mailed in early summer with instructions.

During the summer months, inquiries regarding the medical record are received weekday mornings after 8:30 a.m. at 570-577-1401. The office is closed during the afternoon.
DIRECTIONS FOR PREPARING AND RETURNING THE BUCKNELL STUDENT HEALTH MEDICAL RECORD

A. **DEMOGRAPHICS** PRINT CAREFULLY IN INK information requested. Also PRINT your name on all pages where indicated.

B. **PART I – MEDICAL HISTORY** Ask your parents, guardian, or family physician to assist in completing this section.

C. **PART II – CONSENT FOR TREATMENT** SIGN and DATE (signature of parent/legal guardian necessary if student is under age 18).

D. **PART III – IMMUNIZATION RECORDS** Complete (with the assistance of your physician, if necessary) all information requested on the form. A copy of vaccine records from your medical provider should be included.

**REQUIRED IMMUNIZATIONS:**

1) **Hepatitis B:** A 3-shot series is required. The first of three (3) must have been given prior to enrollment at Bucknell. The series must be completed within one (1) year. (There must be at least four (4) weeks between doses 1 and 2 and at least eight (8) weeks between doses 2 and 3. Overall there must be at least four (4) months between doses 1 and 3.) A blood test showing immunity will be acceptable by providing lab reports.

2) **Measles, Mumps, Rubella (MMR):** Two (2) single doses of live measles (rubeola), mumps, and rubella vaccine or two (2) combined doses of MMR vaccine at least 28 days apart after 12 months of age and since 1981 are required. A blood test showing immunity to measles, mumps and rubella will also be acceptable by providing lab reports. Having had the diseases diagnosed is not sufficient.

3) **Meningitis (Meningococcal vaccine – A,C,Y, W-135):** you must either check the box indicating you have had the vaccine since August 2014 and enter the date of the vaccine OR check the box indicating you have declined the vaccine. The student’s signature (or parent/legal guardian’s signature if the student is under age 18) is required no matter which box is checked. Meningitis B vaccine is not required but is recommended.

4) **Polio (OPV or IPV):** Dates of basic series and last booster (administered at least one year following completion of basic series and after age 4).

5) **Tetanus/Diphtheria/Pertussis (TDAP) or Booster:** A TDAP vaccine since August 2007 is required. TDAP may be administered regardless of interval since the last tetanus or diphtheria toxoid-containing vaccine.

6) **Chicken Pox (Varicella):** Requirement is: history of having the disease; or two (2) doses of vaccine (the second dose at least 12 weeks after first dose if administered between ages 1-12 years or at least 4 weeks after first dose if administered at age 13 years or older); or blood test report showing immunity.

E. **PART IV – PHYSICAL EXAMINATION** Arrange for a physical examination (requirement is for a physical within one year prior to your first day of class at Bucknell) and have PART IV completed and signed by the physician or medical provider after reviewing the immunization requirements listed above. PLEASE SHOW THIS INSTRUCTION SHEET TO YOUR PHYSICIAN OR MEDICAL PROVIDER.

F. **PART V – TUBERCULOSIS SCREENING QUESTIONNAIRE** Page 1 to be completed by student and reviewed by Medical Provider. Provider to complete and sign Part V Page 2 only if student answered yes to Part V Page 1. Part V Page 2 – TST interpretation should be based on mm of induration as well as risk factors.

G. **INSURANCE INFORMATION** – Complete the form and attach a copy, front and back, of your health insurance cards.

H. Return the entire completed medical form to Bucknell Student Health no later than June 15 for fall enrollment or January 3 for spring enrollment. **YOU WILL NOT BE ABLE TO OBTAIN YOUR DORM ROOM KEY IF YOUR MEDICAL RECORD IS NOT RECEIVED OR IS INCOMPLETE.**
This form must be completed in English in its entirety and the original sent to Bucknell Student Health, Bucknell University, Lewisburg, PA 17837 no later than June 15 for fall enrollment or January 3 for spring enrollment. Failure to comply will prevent student from obtaining your dorm room key.

During the summer months, inquiries regarding the medical record are received weekday mornings after 8:30 a.m. at 570-577-1401. The office is closed during the afternoon.

### DEMOGRAPHICS

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<th>Admitted as a</th>
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PLEASE PRINT NAME LEGIBLY IN INK

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<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
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<th>HOME ADDRESS</th>
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<td>Street Address</td>
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<tr>
<th>CITY</th>
<th>STATE / ZIP CODE</th>
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<tr>
<th>Student Cell Phone</th>
<th>Home Phone</th>
<th>D.O.B.</th>
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Name of Parent/Guardian

Parent/Guardian Cell Phone

(____) ______________________

**PART I — MEDICAL HISTORY**

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<th>Question</th>
<th>No</th>
<th>Yes (specify)</th>
<th>Remarks or additional information (use additional sheet if necessary)</th>
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<tr>
<td>Have you been diagnosed with ADD/ADHD?</td>
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<td>Are you presently being treated for any condition?</td>
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<td>Do you have a history of asthma?</td>
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<td>Do you have a history of diabetes?</td>
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<td>Have you ever had a concussion?</td>
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<td>How many?</td>
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<tr>
<td>Have you ever received treatment for any psychiatric, mental health, disordered eating or psychological condition? Explain.</td>
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**PART II — CONSENT FOR TREATMENT**

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.

My signature below indicates that:

- I consent to medical and nursing treatment by the Bucknell Student Health staff.
- I am aware of the Notice of Privacy Practices available at: [www.bucknell.edu/HealthPrivacy](http://www.bucknell.edu/HealthPrivacy)
- The information on this form is correct and complete to the best of my knowledge.
- If I require services, prescriptions, or referrals beyond the primary care services available at Bucknell Student Health, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.
- I understand that my contacts with Bucknell Student Health are held in confidence, but that confidentiality may be broken if my life or that of another person is in danger.
- I have attached a copy, front and back, of all health insurance cards.

Signature of Student ______________________ Date ______________________

Signature of parent/guardian ______________________ Date ______________________

(Required if student is under age 18 and not a high school graduate)
If the immunization requirements are not met, the student will NOT be permitted to obtain their dorm room key. Please record dates (month/day/year) below and also include a copy of vaccine records from your medical provider.

**NAME**

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**D.O.B.** ________/_______/_______

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<th>Month</th>
<th>Day</th>
<th>Year</th>
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### REQUIRED IMMUNIZATIONS

1. **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.

   - **1st Dose Date**: M/D/Y
   - **2nd Dose Date**: M/D/Y
   - **3rd Dose Date**: M/D/Y
   - **Booster Date**: M/D/Y

2. **MMR (Measles/Mumps/Rubella)** Two (2) doses after age 12 months, given at least 28 days apart, and since 1981. Blood test reports indicating immunity are acceptable.

   - **1st Dose Date**: M/D/Y
   - **2nd Dose Date**: M/D/Y

3. **MENINGITIS** – Please check the statement that applies and sign:

   - _____ I have received the meningitis vaccine (Serogroup A,C,Y, W135) (Menactra, Menevo or Menomune since August 2014.
     **Vaccine Date** /_____/______

   - _____ I have read and understand the enclosed information about meningitis, and I decline the A,C,Y, W135 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 Bucknell Student Health.

   **Date** ____________

   **Student’s Signature or Parent’s Signature** if student is under age 18 or not yet graduated from high school

4. **Polio (OPV or IPV)** Basic series of three doses and last booster (at least one year following completion of basic series) and after age four.

   - **1st Dose Date**: M/D/Y
   - **2nd Dose Date**: M/D/Y
   - **3rd Dose Date**: M/D/Y
   - **Booster Date**: M/D/Y

5. **TDAP (Tetanus/Diphtheria/Pertussis) Vaccine** since August 2007

6. **Varicella (Chicken Pox)** Two doses required* 

   - **1st Dose Date**: M/D/Y
   - **2nd Dose Date**: M/D/Y

*First dose must be given after 12 months of age or History of having the disease, vaccine, or blood test report indicating immunity by providing laboratory report is acceptable.

### OTHER IMMUNIZATIONS RECEIVED (not required):

- **Hepatitis A**
- **HPV (Human Papillomavirus Vaccine)**
- **Meningitis - Serogroup B (New Vaccine):**
  - Bexsero
  - Trumenba
- **Pneumococcal:**
- **Typhoid Oral**
- **Typhoid IM**
- **Other:**

### TUBERCULOSIS SCREENING – SEE SEPARATE FORM
To the examining physician: Please review the student’s history and complete Parts IV & V. Please comment on all positive answers.

NAME __________________________________________________________________________________________

BP ___________________ PULSE ___________________ HT ___________ WT _________ BMI __________

D.O.B. ________/_________/_________  

   Month        Day           Year

Current medications, dosages and frequencies:  No______ Yes______ Please list: ________________________________________________

____________________________________________________________________________________________________________________________

Allergies to medication:  No______ Yes______ Please list: ________________________________________________

Allergies to food or environment:  No______ Yes______ Please list: ________________________________________________

Are there abnormalities of the following systems? Describe fully.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Comments (use additional sheet if needed)</th>
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<tbody>
<tr>
<td>1.</td>
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<td>Head, Eyes, Ears, Nose or Throat</td>
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<td>9.</td>
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<td>Concussion (if yes, how many?)</td>
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<td>10.</td>
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Has the patient ever been diagnosed for any psychiatric or mental health condition?  No______ Yes______ Explain: ______________________________________________________________________________________________

Has the patient ever been diagnosed with ADD/ADHD?  No______ Yes______

Is there a history of eating disorders?  No______ Yes______ Explain: ______________________________________________________________________________________________

General comments/recommendations: ______________________________________________________________________________________________

____________________________________________________________________________________________________________________________

I certify that to the best of my knowledge the information provided on PART IV of this form is true and complete. __________________

Date __________________ Provider’s Signature __________________

Address ___________________________________________________________________________  

   Street                     City                          State/Zip

Telephone: (_________) ___________________________________________________________________________

Fax: (_________) ___________________________________________________________________________

For Provider’s Stamp
Bucknell Student Health
Tuberculosis (TB) Screening Questionnaire

PART V

TO BE COMPLETED BY STUDENT AND REVIEWED BY MEDICAL PROVIDER.

Student Name: ____________________________________________________________ DOB _____/_____/_____
(PLEASE PRINT) Last Name               First Name   M.I.

1. Have you had a previous positive **TB Skin Test**  □ No □ Yes

2. Have you had a previous positive **IGRA Blood Test**?  □ No □ Yes

3. Have you ever had close contact with persons known or suspected to have active TB disease?  □ No □ Yes

4. Were you born in one of the countries listed below that have a high incidence of active TB disease?  □ No □ Yes
   (If yes, please **CIRCLE** the country, below)

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Medications and Treatments of Coughing (especially if lasting for 3 weeks longer)
with or without sputum production

- Coughing up blood (hemoptysis)
- Unexplained weight loss
- Chest pain
- Night sweats
- Loss of appetite
- Fever

TB Symptom Check: Does the student have signs or symptoms of active pulmonary tuberculosis disease?

- Yes
- No

Required

Tuberculin Skin Test (TST)**
**www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
Date Given: ___/___/____ Date Read: ___/___/____
Result: ________ mm of induration
**Interpretation: positive____ negative____
If no induration write “0”

Interferon Gamma Release Assay (IGRA)
Date Obtained: ___/___/____ (QFT-GIT, T-Spot)
Result: negative____ positive____ indeterminate____
borderline____ (T-Spot only) *Enclose copy of Lab Report

IF POSITIVE

Chest x-ray (Required if TST or IGRA is positive)
Date Obtained: ___/___/____
Result: normal ____ abnormal ____ *Enclose copy of Results

Provide proof of treatment given for positive TB testing:

- Medication ______________________________
- Date Treatment Started _____________________
- Date Treatment Completed _____________________

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Provider Signature ______________________________ Title __________ Date __________
Address ______________________________ Phone __________ Fax __________
BUCKNELL STUDENT HEALTH
INSURANCE INFORMATION

Bucknell University requires all full-time students to have adequate health insurance that covers them every day of their higher education. International students are automatically enrolled in the Bucknell Student Health Insurance Plan and should disregard this page.

International Student: □ Please check box.

All DOMESTIC STUDENTS are required to enroll or waive the Bucknell Student Health Insurance plan online. This form is not a waiver. Postcards will be mailed in early summer with instructions regarding the waiver/enrollment process.

Student Name: ________________________________
(PLEASE PRINT) Last Name First Name M.I.

BU I.D. ________________________________

DOB ____/_____/_____

PARENT/GUARDIAN

Subscriber Information

Subscriber's Name: ________________________________ DOB ____/_____/_____

Gender ________________________________

Relationship to Student: circle one Parent Guardian Other ________________________________

Insurance Information

Name of Insurance Company: ________________________________

Insurance Claims Address: ________________________________ City: ________________ State: ______ Zip: ______

Insurance ID Number: ________________________________ Group Number: ________________________________

Does your insurance cover out of area non-emergent care? □ No □ Yes

Does your insurance have out of network benefits? □ No □ Yes

Is your insurance carrier contracted with Evangelical Hospital? □ No □ Yes

Is your insurance carrier contracted with Geisinger Medical Center? □ No □ Yes

Please place copies of the front and back of your insurance card below.

FRONT OF INSURANCE CARD

BACK OF INSURANCE CARD

*Please provide copies of any additional health insurance coverage.
MENINGITIS INFORMATION

College students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, first-year students living in residence halls are found to have a six-fold increased risk for the disease. The American College Health Association recommends that college students, particularly first-year students living in university housing, learn more about meningitis and vaccination. At least 70% of all cases of meningococcal disease in college students are vaccine preventable.

On July 28, 2002, the Pennsylvania Governor signed legislation (Senate Bill 955) which requires that all students residing in university housing either have the ACY & W135 (Menactra, Menveo, Menomune) vaccine or sign a declination statement after review of written information concerning the benefits of receiving the ACY & W135 meningitis vaccine.

The Meningitis B specific vaccine (Bexsero, Trumenba) is not a part of the 2002 legislation. Although this vaccine is not required, it is a recommended vaccine.

• What is meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of membranes surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

• How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items such as utensils, cigarettes and drinking glasses.

• What are the symptoms? Symptoms of meningococcal meningitis often resemble influenza and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, and confusion.

• Who is at risk? Certain college students, particularly first-year students who live in residence halls, have been found to have an increased risk for meningococcal meningitis.

• Can the chance of contracting meningitis be reduced? Yes. Safe and effective vaccines are available; one is to protect against Groups A, C, Y, and W-135 and the other protects against Group B.

To learn more about meningitis and the vaccine, visit Bucknell Student Health or call 570-577-1401. Information is also available on:

  o The American College Health Association website, www.acha.org