Bucknell UNIVERSITY | Student Health

Bucknell Student Health Provider Packet

First Year, Transfer students, Summer students, Graduate students using Student Health as their Medical Provider

- ☐ Print packet
- ☐ Take entire packet to doctors office
- ☐ Complete the physical form on our packet. Attachments will not be accepted.
- ☐ Immunization form needs to be filled out. Please also attach a print out from your doctor's office.
- ☐ Complete QuantiFERON gold test, lab results must be submitted for review
- ☐ Upload and submit entire packet for review
- ☐ Make sure demographic page is completed and submitted for review
- ☐ Make sure insurance page is completed and submitted for review
- ☐ Be sure to check your Bucknell email for additional information

Graduate students- Not using Student Health as their medical provider

You will need to submit the QuantiFERON gold results and Immunization sheet. You do not need to complete a physical form unless you plan to use Student Health as your medical provider.

- ☐ Print packet
- ☐ Complete immunization form. Please also attach a print out from your doctor's office
- ☐ Complete QuantiFERON gold test, lab results must be submitted for review
- ☐ Upload and submit packet for review
- ☐ Make sure demographic page is completed and submitted for review
- ☐ Make sure insurance page is completed and submitted for review
- ☐ Be sure to check your Bucknell email for additional information

Geisinger

WellSpan Evangelical Community Hospital

A Joint Venture of Evangelical-Geisinger Health, LLC

IMMUNIZATION RECORDS

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 **must** include a copy of vaccine records from your medical provider. Medical records deadline is June 15th for fall semester.

NAME _____ D.O.B ____ / ____ / ____
Last First Middle Month Day Year

REQUIRED IMMUNIZATIONS THIS SECTION MUST BE COMPLETED AND FILLED OUT. ANY BLOOD TEST REPORT SHOWING IMMUNITY MUST BE ATTACHED.	**1st Dose Date**	**2nd Dose Date**	**3rd Dose Date**	**Booster Date**
Hepatitis B A 3-shot series is required. First of 3 must have been prior to enrollment at Bucknell. Adolescents age 11-15 may use alternative 2-dose schedule at least 4 months between doses. A 2-dose schedule is also accepted for ages 18 and older with Heplisav-B. A blood test report indicating immunity is acceptable				
Polio (OPV or IPV) 4-dose series (With the final dose **on or after the 4th birthday and at least 6 months after** the previous dose. Blood test report indicating immunity is acceptable).				
Meningitis – Serogroup A, C, Y, W135 Must be at least one dose administered after age 16				
Meningitis – Serogroup B – Minimum of two doses are required. Please Indicate which brand received. ◯ **Bexsero** ◯ **Trumenba** Dosing schedule varies by vaccination brand.				
MMR (Measles/Mumps/Rubella) 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. A blood test showing immunity to measles, mumps and rubella will also be acceptable by providing lab reports. **Having had the disease diagnosed is not sufficient).**				
Tdap (Tetanus/Diphtheria/Pertussis) Vaccine **since August 2015**				
Varicella (Chicken Pox) 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. **Having had the disease diagnosed is not sufficient**).				

OTHER IMMUNIZATIONS RECEIVED
(not required but strongly recommended):

COVID-19 Most recent ◯ Moderna ◯ Pfizer ◯ J&J ◯ _____			
HPV (Human Papillomavirus Vaccine)			
Hepatitis A			
Pneumococcal			
Typhoid ◯ Oral ◯ IM			
Other:			

◯ **Required: I have enclosed a printout of all immunization records for review, including any lab work that confirms immunity.**

Edited 5/2/2025

PHYSICAL EXAMINATION

A physical examination required for **ALL incoming students**, MUST be done within one (1) year prior to your first day of class at BUCKNELL UNIVERSITY. **Must be completed on this form. Attachments will not be accepted.** Medical provider packets for fall semester are **due by June 15th.**

Name: _____ Date of Birth: ____/ ____ / ____
Last First Middle Month Day Year

	NORMAL	NOT EXAMINED	ABNORMAL - Describe Findings
General Appearance			
Head, Eyes, Ears, Nose, Throat			
Lymph Nodes			
Cardiovascular/Pulses			
Respiratory/Lungs			
Gastrointestinal			
Musculoskeletal			
Neurological			# of concussions
Skin			

BP	P	HT	WT	BMI

Medication Allergies: ○No ○Yes, List _____

Food Allergies: ○No ○Yes, List _____

Environmental Allergies: ○No ○Yes, List _____

History of Anaphylaxis: ○No ○Yes, what was the trigger? _____

Does the student carry an EpiPen or AUviQ? ○No ○Yes

Current medication(s) with **dosage(s)**: ○No ○Yes, List _____

_____

Current nonprescription medication(s) with **dosage(s):** ○No ○Yes, List: _____

_____

Has the patient ever been diagnosed with any psychiatric or mental health condition? ○No ○Yes,
Explain: _____

Has the patient ever been diagnosed with ADD/ ADHD? ○No ○Yes

Is there any history of an eating disorder? ○No ○Yes, Explain: _____

_____

General comments/recommendations: _____

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

Date of Physical Examination: _____

Physician/Healthcare Provider's Signature _____ MD, DO, NP, PA-C

Office Address: _____ ***PROVIDER'S STAMP***

_____

Office Phone: _____

Office Fax: _____

TUBERCULIN TEST PAGE

QuantiFERON Gold

Completing and returning this form are requirements for admission

Name: _____ Date of Birth: _____

BU ID: _____

All students (US and non-US residents)

All US students and non-US resident students must have a **QuantiFERON gold test** (TST will not be accepted) **within the past 6 months prior to the first day of classes.**

QuantiFERON Gold Test

Date of Test: _____

◯ Negative ◯ Positive

◯ I have enclosed documentation that confirms my result.
(Documentation is required)

If you have a Positive result:

Type of Treatment _____

Date of Treatment _____

Documentation of treatment must be attached and returned with this form.

** All positive QuantiFERON gold results must have completed prior to arrival on campus.