BUCKNELL UNIVERSITY

# STUDENT HEALTH MEDICAL FORMS

**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 **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 8:30 – noon at 570-577-1401. The office is closed during the afternoon.**

Bucknell UNIVERSITY | Student Health

**Phone: 570-577-1401 Fax: 570-577-3570**

EVANGELICAL COMMUNITY HOSPITAL
*Excellence Every Day.*

Geisinger

Rev. 12/9/2021

## CHECKLIST/DIRECTIONS FOR PREPARING AND RETURNING THE BUCKNELL STUDENT HEALTH MEDICAL RECORD

◯ A. **DEMOGRAPHICS** PRINT CAREFULLY IN INK IN ENGLISH 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: You must 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 also be attached in addition to completed forms**.

**REQUIRED IMMUNIZATIONS:**

◯ 1) Hepatitis B: A 3-shot series is required and 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.)

◯ 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. 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) 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.

◯ 4) Tetanus/Diphtheria/Pertussis (Tdap) or Booster: A Tdap vaccine **since August 2012** is required.

◯ 5) Chicken Pox (Varicella): 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.

◯ 6) Meningitis (Meningococcal vaccine – A,C,Y, W-135): you must **list the date of the vaccine** indicating you have had the vaccine **after age 16.**

◯ 7) Meningitis Serogroup B series must be completed, please note there is a Meningitis and Meningitis B vaccination – **both vaccinations are required for all students**. Please note if you had Bexsero or Trumenba by checking the box.

◯ 8) **COVID-19 Vaccine(s):** Enter the brand and date(s) of your shots. Also complete the ***COVID-19 VIRUS AND VACCINATION INFORMATION SHEET***.

◯ E. **PART IV –**

1. **PHYSICAL EXAMINATION:** Arrange for a physical examination (requirement is for a physical **within one (1) year, (athletes within six (6) months) prior to your first day of class at Bucknell**) Physical examination needs to be completed on this form, attachments will not be accepted. **Our form must be dated, signed and contain an office stamp**.
2. **TUBERCULOSIS TEST**: Administered and read by physician or provider **6 months prior to start of classes**. **PLEASE SHOW THIS INSTRUCTION SHEET TO YOUR PHYSICIAN OR MEDICAL PROVIDER**.

◯ F. **VARSITY ATHLETES:** Please contact the Athletic Department for a pre-participation form.

◯ 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**.

## DEMOGRAPHICS PLEASE *PRINT* LEGIBLY IN INK — STUDENT

Year of Entrance _____ ○ First-Year ○ Transfer ○ Graduate ○ Summer ○ Other

Legal Name _____
Last First Middle

Preferred Name _____

Home Address _____
Street Address

_____
City State / Zip Code

BU email: _____

Student Cell Phone ( _____ ) _____

Name of Parent/Guardian 1. _____ 2. _____

Parent/Guardian Cell Phone 1. ( _____ ) _____ 2. ( _____ ) _____

BU ID# _____

D.O.B. _____ /_____ /_____

**SEX ASSIGNMENT AT BIRTH**

○Male ○Female ○Intersex

**PREFERRED PRONOUN**

○He ○She ○They ○ _____

**GENDER IDENTITY (PLEASE CHECK)**

○Male ○Gender-queer
○Female ○Gender Non-conforming
○Transwoman ○Transman
○_____

## PART I — MEDICAL HISTORY — STUDENT

| | No | Yes (specify) | Remarks or additional information (use additional sheet if necessary) |
|---|---|---|---|
| Have you been diagnosed with ADD/ADHD? | | | |
| Are you presently being treated for any condition? | | | |
| Do you have a history of asthma? | | | ○Use of inhaler |
| Do you have a history of diabetes? | | | |
| Have you ever had a concussion? How many? | | | |
| Have you ever received treatment for any psychiatric, mental health, disordered eating or psychological condition? Explain. | | | |
| Previous Surgeries? | | | |
| Previous Seizures? | | | |

Age of first period: _____ Periods are: ○ Regular ○ Irregular ○ Absent ○ Excessive, unwanted hair growth. ○ Acne

## PART II — CONSENT FOR TREATMENT — STUDENT

*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
- 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)

## PART III – IMMUNIZATION RECORDS PHYSICIAN AND/OR STUDENT

**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.**

NAME _____
Last First Middle

D.O.B. _____/_____/_____
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 |
|---|---|---|---|---|
| 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 indicating immunity is acceptable. | M/D/Y | M/D/Y | M/D/Y | |
| 2. **MMR** (Measles/Mumps/Rubella) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable. | M/D/Y | M/D/Y | M/D/Y | |
| 3. **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. | M/D/Y | M/D/Y | M/D/Y | M/D/Y |
| 4. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **since August 2012** | M/D/Y | | | |
| 5. **Varicella (Chicken Pox)** Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable. | M/D/Y | M/D/Y | | |
| **IMMUNIZATONS AFTER AGE 16** | | | | |
| 6. **Meningitis –** Serogroup A,C,Y, W135 Menactra, Menveo or Menomune **Must be at least one dose administered after age 16.** | M/D/Y | M/D/Y | | |
| **Please note: Both Meningitis and Meningitis B are both required immunizations** | | | | |
| 7. **Meningitis – Serogroup B - Please indicate which brand received.** ☐ **Bexsero or** ☐ **Trumenba** **Minimum of two doses are required.** | M/D/Y | M/D/Y | M/D/Y | |
| **COVID-19** | | | | |
| **COVID-19 - Please indicate which brand received.** ☐ **Moderna** ☐ **Pfizer** ☐ **Johnson & Johnson** ☐ _____ | M/D/Y | M/D/Y | M/D/Y | |

REQUIRED IMMUNIZATIONS REQUIRED IMMUNIZATIONS

| **OTHER IMMUNIZATIONS RECEIVED** (not required): | 1st Dose Date | 2nd Dose Date | 3rd Dose Date |
|---|---|---|---|
| **Hepatitis A** | | | |
| **HPV (Human Papillomavirus Vaccine)** | | | |
| **Pneumococcal** | | | |
| **Typhoid Oral** | | | |
| **Typhoid IM** | | | |
| **Other:** | | | |

## PHYSICAL EXAMINATION MUST BE COMPLETED ON THIS FORM

**PART IV – PHYSICAL EXAMINATION PAGE 1 OF 2** **PHYSICIAN AND STUDENT**

*Physical examination required for **ALL incoming students**, MUST be done within one (1) year prior to your first day of class at BUCKNELL UNIVERSITY.*
*Physical examination required for **ALL athletes**, MUST be done within six (6) months prior to your first day of class at BUCKNELL UNIVERSITY.*

NAME _____ D.O.B. M_____/D_____/Y_____
Last First Middle

Current prescription and nonprescription medication(s) with **dosage(s)**: ◯ No ◯ Yes, *please list*: _____

_____

Medication Allergies: ◯ No ◯ Yes : _____

Food Allergies: ◯ No ◯ Yes : _____

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

Does student carry an EpiPen or AUviQ? ◯ No ◯ Yes

Physical Examination: BP_____ P _____ HT _____ WT _____ BMI _____ Vision: R 20/_____ L 20/_____

| | 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 | | | |

Has the patient ever been diagnosed with any psychiatric or mental 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.***

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

**Office Address:** _____

_____

**Office Phone:** _____

**Office Fax:** _____

*FOR PROVIDER'S STAMP*

**TST by Mantoux Skin Test (Tuberculin Skin Test) – REQUIRED**
COMPLETING AND RETURNING THIS FORM ARE REQUIREMENTS FOR ADMISSION

## TUBERCULIN QUESTIONNAIRE

NAME _____ BUID _____

| **US RESIDENTS** | **NON-US RESIDENT (this includes dual citizenship)** |
|---|---|
| All US students must have a **Tuberculin Skin Test** (TST by Mantoux method only) **within the past 6 months prior to the first day of classes.** | All 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.** |
| **Tuberculin Skin Test (TST)**<br>Date of Test:_____<br>Signature of Provider Testing:<br>_____<br>Date of Reading: _____<br>Signature of Provider Reading Test:<br>_____<br>○ Negative _____ mm ○ Positive _____ mm | **QuantiFERON Gold Test**<br>Date of Test:_____<br>○ Negative ○ Positive<br>***Lab results must be attached and returned with this form.***<br>**If you have a positive result:**<br>Type of Treatment _____<br>Date of Treatment _____<br>***Documentation of treatment must be attached and returned with this form.*** |
| **If your TST is positive OR you have a History of Positive TST, you must have a QuantiFERON Gold Blood Test.** → | |

** All positive QuantiFERON gold results must either have been treated or agree to treatment in order to stay enrolled.

## COVID-19 VIRUS AND VACCINATION INFORMATION SHEET

NAME _____ BUID _____

**Have you had the COVID-19 virus?** ○ Yes ○ No

If yes, what date were you diagnosed? _____

At the time of testing, were you symptomatic/did you have symptoms? ○ Yes ○ No

If yes, please list all your symptoms:_____

_____

**If you have had a positive COVID-19 test, please send us a copy of your results in your packet.**

Were you hospitalized? ○ Yes ○ No

Did you receive any treatment for COVID? ○ Yes ○ No

Medications administered _____

Did they give you oxygen? ○ Yes ○ No

Other: _____

Do you have any ongoing, residual symptoms? ○ Yes ○ No

If yes, please list current/ residual symptoms: _____

_____

Date of last COVID test _____

**Will you be playing on a varsity athletic team at Bucknell?** ○ Yes ○ No

If yes, please list which sport: _____

**Have you had a COVID-19 vaccination?** ○ Yes ○ No

If yes, what date(s) were you immunized? _____

Which brand did you receive? _____

If no, what are your scheduled vaccine dates(s)? _____

What brand will you be receiving? _____

COPY OF COVID
VACCINATION CARD HERE

## 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

Date of Arrival: _____

insurance@bucknell.edu

*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 __M__/__D__/__Y__

| BIRTH GENDER |
|---|
| ○Male ○Female ○Intersex |

| PREFERRED PRONOUN |
|---|
| ○He ○She ○ _____ |

### PARENT/GUARDIAN

#### SUBSCRIBER INFORMATION

Subscriber's Name: _____ DOB __M__/__D__/__Y__

Gender _____

Relationship to Student: (*circle one)* Parent Guardian Other _____

#### INSURANCE INFORMATION

Name of Insurance Company: _____

Insurance Claims Address: _____

Insurance ID Number: _____ Group Number: _____

Is your insurance plan a State Medicaid Plan? ◯ No ◯ Yes

Coordination of Benefit (COB) issues can occur with your Primary Insurance. COB issues can arise when your primary insurance believes that another policy exists and is available for payment of services. If this occurs, we may need to contact you or the policy subscriber to update COB information with your policy.

Do you permit Student Health to contact the insurance subscriber to handle COB related issues? ◯ 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.*