SUMMER SESSION STUDENTS HEALTH FORM
COMPLETING AND RETURNING THIS FORM IS REQUIRED

Bucknell UNIVERSITY

YOUR GENERAL INFORMATION

Name _____ Date of Birth _____

Permanent Address _____

Primary Telephone: ( ) _____ Email Address: _____

BU ID No. _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to You _____

Address _____

_____

Primary Telephone: ( ) _____ Other Telephone: ( ) _____

BIRTH GENDER		
○Male	○Female	○Intersex

PREFERRED PRONOUN		
○He	○She	○Other _____

GENDER IDENTITY (PLEASE CHECK)		
○Male	○Gender-queer	○Something else
○Female	○Gender Non-confirming	
○Transwoman	○Transman	

GENERAL HEALTH INFORMATION

Describe any disabilities or injuries you may have:_____

Describe any chronic illness you may have: _____

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.

	No	Yes	Comments (use additional sheet if needed)
1. Head, Eyes, Ears, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neurologic			
10. Concussion (if yes, how many?)			
11. Skin			

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 any history of an eating disorder? No_____ Yes_____ Explain: _____

_____

General comments/recommendations: _____

_____

EVANGELICAL COMMUNITY HOSPITAL
Excellence Every Day.

Geisinger

IMMUNIZATIONS

Tdap (Tetanus, Diphtheria and Pertussis) vaccine since **August 2009**. Vaccine date _____

MMR (Measles/Mumps/Rubella) Two (2) doses after age 12 months, given at least 28 days apart. Blood test reports indicating immunity are acceptable – please attached them to this form.

MMR 1st Dose Date: _____

MMR 2nd Dose Date: _____ **OR** Blood test reports attached.

MENINGITIS
Meningitis vaccine **(Serogroup A,C,Y, W135) (Menactra, Menveo or Menomune) AFTER AGE 16**.

Vaccine Date _____.

MENINGITIS – Serogroup B, Bexsero or Trumenba is not required but strongly recommended.

Vaccine Date _____.

TST by Mantoux Skin Test (Tuberculin Skin Test)
All students must have a Tuberculin skin test (TST by Mantoux method only)
within the past 6 months prior to the start of the semester.

Date of Test _____ Signature of Provider Testing _____

Date of Reading _____ ○ Negative _____ mm ○ Positive _____ mm

Signature of Provider Reading Test_____

If test Positive: QuantiFERON Gold Test Date _____ Results: ○ Negative ○ Positive

Please attached results.

Any Treatment _____ Date of Treatment _____

HEALTH INSURANCE INFORMATION:
Complete the attached **INSURANCE INFORMATION FORM.**

I verify that all the above information is correct and I am aware of the Notice of Privacy Practices available at: **bucknell.edu/HealthPrivacy**

Student Signature _____ Date _____

Parent Signature required if student is under age 18 and not a high school graduate.

_____ Date _____

PLEASE COMPLETE THIS FORM AND RETURN IT TO:
Bucknell Student Health, Bucknell University, One Dent Drive, Lewisburg, PA 17837
Telephone: 570.577.1401 Fax: 570.577.3570

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.

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 _____/_____/_____

BIRTH GENDER
○Male ○Female ○Intersex

PREFERRED PRONOUN
○He ○She ○Other _____

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.*