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 – 11 a.m. at 570-577-1401. The office is closed during the afternoon.

Bucknell UNIVERSITY

Bucknell Student Health
One Dent Drive
Lewisburg, PA 17837
Phone: 570-577-1401
Fax: 570-577-3570

EVANGELICAL COMMUNITY HOSPITAL
Excellence Every Day.

Geisinger

Rev. 1/2020

CHECKLIST/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: 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 2010** 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 diseases 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.

◯ E. **PART IV –**

1. **PHYSICAL EXAMINATION:** Arrange for a physical examination (requirement is for a physical **within one year prior to your first day of class at Bucknell**)
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**.
3. **PHYSICIAN SIGNATURE MUST BE COMPLETED.**

◯ F. **PART V – TO BE COMPLETED BY VARSITY ATHLETIC STUDENTS.** All other students may skip this section.

◯ G. **Varsity Athletes Only.** Please mail this form to Bucknell Student Health, One Dent Drive, Lewisburg, PA 17837, **AND ALSO** upload form and **sickle cell results** to sportsware online (www.swol123.net)

◯ H. **INSURANCE INFORMATION: Complete the form and attach a copy, front and back, of your health insurance cards.**

◯ I. 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**.

Bucknell UNIVERSITY
Bucknell Student Health
Lewisburg, PA 17837
Phone: 570-577-1401
Fax: 570-577-3570

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 their 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 PLEASE *PRINT* LEGIBLY IN INK — STUDENT

YEAR OF ENTRANCE _____ ○ First-Year ○ Transfer ○ Graduate ○ Other

LEGAL NAME _____
LAST FIRST MIDDLE

PREFERRED NAME _____

HOME ADDRESS _____
STREET ADDRESS

_____
CITY STATE / ZIP CODE

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 ○_____

GENDER IDENTITY (PLEASE CHECK)
○Male ○Gender-queer
○Female ○Gender Non-confirming
○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?			

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 also include a copy of vaccine records from your medical provider.

NAME _____
Last First Middle

D.O.B. _____/_____/_____
Month Day Year

REQUIRED IMMUNIZATIONS

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. Blood test reports indicating immunity are 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 reports indicating immunity is acceptable.	M/D/Y	M/D/Y	M/D/Y	M/D/Y
4. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **since August 2010**	M/D/Y			
5. **Varicella (Chicken Pox)** Two (2) doses **after age 12 months**, given at least 28 days apart. Blood test reports indicating immunity are 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	

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

Physical examination acceptable only if done within one (1) year prior to your first day of class at Bucknell and completed on our form by a Physician or Provider.

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

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

BP _____ PULSE _____ HT _____ WT_____ BMI _____

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:_____

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

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: _____

_____

Age of menarche _____ Periods are: Regular _____ Irregular _____ Hirsutism _____

General comments/recommendations: _____

_____

_____

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) Date of Test:_____ Signature of Provider Testing: _____ Date of Reading: _____ Signature of Provider Reading Test: _____ ○ Negative _____ mm ○ Positive _____ mm	**QuantiFERON Gold Test** Date of Test:_____ ○ Negative ○ Positive ***Lab results must be attached and returned with this form.*** If you have a positive result: Type of Treatment _____ Date of Treatment _____ ***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.	

PHYSICIAN SIGNATURE

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_____

For Provider's Stamp

NAME_____

PART V — VARSITY ATHLETES MUST ALSO COMPLETE THIS SECTION. ALL OTHER STUDENTS SKIP TO PAGE 6

SICKLE CELL SCREEN:

Date of screen_____ Results of screen_____

*If drawn today or pending recent results, athlete is responsible for submitting to Bucknell Sports Medicine via their sportsware account (swol123.net)

○ **CLEARED** ○ **CLEARED**, with recommendation(s) for further evaluation or treatment for: _____

○ **NOT CLEARED** for the following types of sports (please check those that apply):

○ COLLISION ○ CONTACT ○ NON-CONTACT ○ STRENUOUS ○ MODERATELY STRENUOUS ○ NON-STRENUOUS

Due to _____

PHYSICIAN SIGNATURE

Date_____ Provider's Signature_____

For Provider's Stamp

›› ATHLETES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Has a doctor ever denied or restricted your participation in sports for any reason? ○ Yes ○ No
2. Have you ever passed out or nearly passed out **DURING** exercise? ○ Yes ○ No
3. Have you ever passed out or nearly passed out **AFTER** exercise? ○ Yes ○ No
4. Have you ever had discomfort, pain, or pressure in your chest during exercise? ○ Yes ○ No
5. Does your heart race or skip beats during exercise? ○ Yes ○ No
6. Has your doctor ever told you that you have (check all that apply) ○ Yes ○ No
   ○ high blood pressure ○ heart murmur ○ high cholesterol ○ heart infection
7. Has your doctor ever ordered an ECG echocardiogram? ○ Yes ○ No
8. Has anyone in your family died for no apparent reason? ○ Yes ○ No
9. Does anyone in your family have a heart problem?
10. Has any family member or relative been disabled from heart disease or died of heart problems Or sudden death before age 50? ○ Yes ○ No
11. Does anyone in your family have Marfan syndrome? ○ Yes ○ No
12. Have you ever spent the night in a hospital? ○ Yes ○ No
13. Were you born without or are you missing a kidney, an eye, testicle, or any other organ? ○ Yes ○ No
14. Have you ever had a seizure? ○ Yes ○ No
15. Has your doctor told you that you or someone in your family has sickle cell disease? ○ Yes ○ No

›› PLEASE SEE PAGE 5 IF YOU HAVE ANSWERED YES TO ANY OF THESE QUESTIONS.

NAME_____

›› IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON PAGE 4, PLEASE EXPLAIN BELOW.

Question #'s	Explain "Yes" answers 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.

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.

BIRTH GENDER
○Male ○Female ○Intersex

BU I.D. _____

DOB __M__/__D__/__Y__

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: _____ 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.*