

INFORMATION FOR GRADUATE STUDENTS REGARDING MEDICAL CARE

As a graduate student at Bucknell University, you have the option to utilize Bucknell Student Health (BSH) for your medical care and health education needs, or you may choose to continue receiving medical treatment from your family physician.

If you choose to use BSH, the **Incoming Undergraduate Medical Record Form** must be completed in its entirety and returned to BSH prior to registration. The form and instructions are available online at bucknell.edu/StudentHealth (Medical Forms)

If you prefer to continue with your current health care provider, Bucknell requires:

- **(TB)** Screening that has been completed and signed by a medical provider.
- **Tdap** (Tetanus, Diphtheria and Pertussis) vaccine since **August 2012**.
- **MMR** (Measles/Mumps/Rubella) Two doses after age 12 months, given at least 28 days apart, and since 1981. Blood test reports indicating immunity are acceptable.
- **Meningitis** vaccine received **AFTER AGE 16**.
- **COVID-19** vaccine(s)

The form for reporting these vaccines (Graduate/Non-Degree Students Medical Requirements for Admission form) is available online at bucknell.edu/StudentHealth (Medical Forms). This document must be completed and returned to BSH prior to registration.

Failure to comply with TB/TDAP/MMR/Meningitis requirements will prevent you from registering for classes.

Bucknell
UNIVERSITY

Student Health

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


EVANGELICAL
COMMUNITY HOSPITAL
Excellence Every Day.

Geisinger

**GRADUATE/NON-DEGREE STUDENTS
COMPLETING AND RETURNING THIS FORM ARE REQUIREMENTS FOR ADMISSION**

Student Name (please print) _____
 BU ID No. _____ Date of Birth _____
 Address/Primary Phone NO. _____
 Admitted as a (check one): _____ Graduate _____ Non-Degree
 Session (check one): _____ Fall _____ Spring _____ Summer

BIRTH GENDER		
<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Intersex

PREFERRED PRONOUN		
<input type="radio"/> He	<input type="radio"/> She	<input type="radio"/> _____

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.

GENDER IDENTITY (PLEASE CHECK)	
<input type="radio"/> Male	<input type="radio"/> Gender-queer
<input type="radio"/> Female	<input type="radio"/> Gender Non-confirming
<input type="radio"/> Transwoman	<input type="radio"/> Transman
<input type="radio"/> _____	

Tdap (Tetanus, Diphtheria and Pertussis) vaccine since **August 2012**. Vaccine date _____

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

Vaccine Dates _____

MENINGITIS – Serogroup B – Please indicate which brand: Bexsero or Trumenba.

Vaccine Dates _____

COVID-19 – Please indicate which brand received.

Moderna Pfizer Johnson & Johnson _____

Vaccine Dates _____

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


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)**

<p>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.</p>	<p>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.</p>
<p>Tuberculin Skin Test (TST)</p> <p>Date of Test: _____</p> <p>Signature of Provider Testing: _____</p> <p>Date of Reading: _____</p> <p>Signature of Provider Reading Test: _____</p> <p><input type="radio"/> Negative ____ mm <input type="radio"/> Positive ____ mm</p>	<p>QuantiFERON Gold Test</p> <p>Date of Test: _____</p> <p><input type="radio"/> Negative <input type="radio"/> Positive</p> <p><i>Lab results must be attached and returned with this form.</i></p> <p>If you have a positive result:</p> <p>Type of Treatment _____</p> <p>Date of Treatment _____</p> <p><i>Documentation of treatment must be attached and returned with this form.</i></p>
<p>If your TST is positive OR you have a History of Positive TST, you must have a QuantiFERON Gold Blood Test.</p>	<div style="text-align: center;">  </div>

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

COVID-19 VIRUS AND VACCINATION INFORMATION SHEET

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: _____

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: _____

If you have had a positive COVID-19 test, please send us a copy of your COVID-19 test result as soon as possible. You can either fax your test result to 570-577-3570 or email your test result to medicalrecords@bucknell.edu.

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? _____