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. 5/13/2021

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 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.

◯ 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 Only.** Please upload the **completed packet & sickle cell test results** to athletic ARMS account (my.armssoftware.com) for athletic participation **BEFORE** mailing the completed packet to Bucknell Student Health, One Dent Drive, Lewisburg, PA 17837 for school enrollment. *Substitute forms will not be accepted.

◯ G. Authorization to release medical information to parent or guardian. **(Optional)**

◯ 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**.

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-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.

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 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 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		

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. _____/_____/_____
Last First Middle Month Day Year

MEDICAL and SURGICAL HISTORY, ***please indicate if student has a history of any of the following:***

ADD / ADHD	Yes	No	Eating Disorder	Yes	No	Immunocompromsing Condition	Yes	No	Rheumatoid Arthritis (or JIA)	Yes	No
Anemia	Yes	No	Headache Disorder	Yes	No	Infectious Mononucleosis	Yes	No	Seizure Disorder	Yes	No
Asthma	Yes	No	Head Injury / Concussion	Yes	No	Inflammatory Bowel Disease	Yes	No	Sickle Cell Disease	Yes	No
Cardiac Arrythmia	Yes	No	Heart Infection	Yes	No	Lupus (SLE)	Yes	No	Sickle Cell Trait	Yes	No
Celiac Diseas	Yes	No	Heart Murmur	Yes	No	Marfan Syndrome	Yes	No	Skin Condition (Please Specify)	Yes	No
COVID-19	Yes	No	High Cholesterol	Yes	No	Polycystic Ovarian Syndrome	Yes	No	Syncope	Yes	No
Diabetes Mellitis	Yes	No	Hypertension	Yes	No	Psychiatric Disorder (Please Specify)	Yes	No	Thyroid Disorder	Yes	No

Provide details for any YES Answers: _____

_____

Was the student born without, or is he/she/they missing a kidney, eye, testicle, ovary, or any organ? ☐ NO ☐ YES:_____
Prior Surgery? ☐ NO ☐ YES, *provide details*: _____
Prior Hospitalization? ☐ NO ☐ YES, *provide details*: _____
Age of Menarche _____ Periods are: ☐ Regular ☐ Irregular ☐ Absent ☐ Hirsutism
Have you ever experienced the following during or after exercise? (Check all that apply)
☐ Chest pain or Discomfort ☐ Chest Pressure ☐ Passed out ☐ Racing Heart ☐ Heart skips a beat ☐ None
Has your doctor ever ordered an EKG, echocardiogram, or cardiac MRI? ☐ No ☐ Yes (Please specify) _____
Has anyone in your family died suddenly for no apparent reason? ☐ No ☐ Yes
Does anyone in your family have a heart problem? ☐ No ☐ Yes
Has any family member or relative been disabled from heart disease, died of heart problems or sudden death before the age of 50? ☐ No ☐ Yes
Current prescription and nonprescription medication(s) with dosage(s): _____

_____

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			
Genitourinary			
Musculoskeletal			
Neurolgical			# of Concussions? _____
Skin			

THIS SECTION IS REQUIRED FOR VARSITY ATHLETIC PARTICIPATON

***This student has been tested for sickle cell trait**: ☐ NO ☐ YES,*must provide documentation of test results. Date of Screen* _____
After physical examination I have found the patient for collegiate sports participation: *(specify sport)*_____
☐ CLEARED – NO RESTRICTIONS
☐ CLEARED – WITH LIMITATIONS (please specify) _____
☐ NOT MEDICALLY CLEARED (Please provide details) _____

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) 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.	

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? _____

MEDICAL RELEASE FORM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

FEE MAY APPLY

PLEASE FILL OUT

Patient name: _____
Address: _____
City, State, Zip: _____
Date of birth: _____
Medical record number: _____
Phone number: _____

This form is used by all provider entities of the Geisinger Health (which is not a provider entity) including Geisinger Medical Center (all campuses), Geisinger Wyoming Valley Medical Center (all campuses), Geisinger Clinic (all sites), Geisinger Community Medical Center (all campuses), Geisinger Bloomsburg Hospital, Geisinger Lewistown Hospital, Geisinger Holy Spirit Hospital (all campuses), Geisinger Holy Spirit Medical Group (all sites), Geisinger Jersey Shore Hospital, and all other provider entities as outlined in the Geisinger Notice of Privacy Practices ***but excluding*** Marworth, and Geisinger Community Health Services.

I am requesting records from the following Geisinger entities:

☐ **All Sites** ☒ **Specific Clinic(s) or Hospital(s):** BUCKNELL STUDENT HEALTH

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to:

Name of hospital, company, or person to whom the information will be released to: _____

Complete address: _____

Telephone number: _____ Fax number: _____ Email address: _____

Parent/Guardian Name: _____ Telephone number: _____

***I am requesting that the information be produced (choose one):** ☐ Paper copies ☐ Fax ☐ Download to Email ☐ CD

***For the purpose of:** ☐ continuation of medical treatment ☐ payment of bill ☐ Worker's Compensation ☐ education

☐ legal purposes ☐ insurance purposes ☒ at the request of the patient or the patient's legal representative

☐ Other (specify): _____

*The information to be released will cover the **time period** from 8 / 1 / 21 to 5 / 31 / 22 . ("present" equals date of signature)

***SPECIFIC INFORMATION TO RELEASE:**

☐ Clinic Notes	☐ EEG, EKG, Stress Test	☐ Immunizations	☐ Pathology Reports
☐ Colonoscopy	☐ Emergency Dept. Notes	☐ Laboratory Reports	☐ X-Ray Reports
☐ Consultation Report(s)	☐ Endoscopy	☐ Medications	☐ X-Ray Films
☐ Discharge Summary	☐ History & Physical	☐ Operative Report(s)	☐ Itemized Bills

☒ Other (specify): ALL MEDICAL RECORD INFORMATION

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the Geisinger Privacy Office immediately at systemprivacyoffice@geisinger.edu or 570-271-7360 if I wish to revoke this authorization. I also understand that this consent will expire six months after the date of signature or automatically when the records requested on this authorization have been released (which ever occurs first). I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party

SPECIAL AUTHORIZATION (IF APPLICABLE)

Patient initials	Parent/Guardian initials	If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.
_____ (initials)	_____ (initials)	My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released.
_____ (initials)	_____ (initials)	My evaluation, testing, diagnosis or treatment concerning my inpatient or involuntary mental health/rehabilitation treatment may be released.
_____ (initials)	_____ (initials)	My testing, diagnosis or treatment for HIV/AIDS may be released.

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date/Time: _____ **Student Signature:** _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because: _____

Date/Time: _____ **Signature:** _____
(Parent/legal or personal representative)

Description of personal representative's authority to act for the patient: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT******

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

Is your insurance carrier contracted with UPMC? ◯ 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.*