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.
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.armsofsoftware.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**

<table>
<thead>
<tr>
<th><strong>YEAR OF ENTRANCE</strong></th>
<th>○ First-Year  ○ Transfer  ○ Graduate  ○ Other</th>
<th><strong>BU ID#</strong></th>
<th><strong>D.O.B.</strong></th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th><strong>LEGAL NAME</strong></th>
<th><strong>LAST</strong></th>
<th><strong>FIRST</strong></th>
<th><strong>MIDDLE</strong></th>
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<table>
<thead>
<tr>
<th><strong>PREFERRED NAME</strong></th>
<th><strong>LAST</strong></th>
<th><strong>FIRST</strong></th>
<th><strong>MIDDLE</strong></th>
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<thead>
<tr>
<th><strong>HOME ADDRESS</strong></th>
<th><strong>STREET ADDRESS</strong></th>
<th><strong>CITY</strong></th>
<th><strong>STATE / ZIP CODE</strong></th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th><strong>Student Cell Phone</strong></th>
<th>(______) __________________________</th>
</tr>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th><strong>Name of Parent/Guardian 1.</strong></th>
<th>2.  __________________________</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Parent/Guardian Cell Phone</strong> 1.</th>
<th>(______) __________________________</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th><strong>SEX ASSIGNMENT AT BIRTH</strong></th>
<th>○ Male  ○ Female  ○ Intersex</th>
</tr>
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<table>
<thead>
<tr>
<th><strong>PREFERRED PRONOUN</strong></th>
<th>○ He  ○ She  ○ ____________________</th>
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</table>

<table>
<thead>
<tr>
<th><strong>GENDER IDENTITY (PLEASE CHECK)</strong></th>
<th>○ Male  ○ Gender-queer  ○ Female  ○ Gender Non-conforming  ○ Transwoman  ○ Transman</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### PART I — MEDICAL HISTORY

<table>
<thead>
<tr>
<th><strong>No</strong></th>
<th><strong>Yes (specify)</strong></th>
<th><strong>Remarks or additional information (use additional sheet if necessary)</strong></th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

- 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? ____________

<table>
<thead>
<tr>
<th><strong>Age of first period:</strong></th>
<th>____________</th>
<th><strong>Periods are:</strong></th>
<th>○ Regular  ○ Irregular  ○ Absent  ○ Excessive, unwanted hair growth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### PART II — CONSENT FOR TREATMENT

**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](http://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)
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

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>D.O.B.</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

#### Required Immunizations

This section must be completed and filled out. Any blood test report showing immunity must be attached.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>1st Dose Date</th>
<th>2nd Dose Date</th>
<th>3rd Dose Date</th>
<th>Booster Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Hepatitis B</strong> 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.</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td></td>
</tr>
<tr>
<td><strong>2. MMR (Measles/Mumps/Rubella)</strong> Two (2) doses after age 12 months, given at least 28 days apart. A blood test report indicating immunity is acceptable.</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td></td>
</tr>
<tr>
<td><strong>3. Polio (OPV or IPV)</strong> 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.</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td></td>
</tr>
<tr>
<td><strong>4. Tdap (Tetanus/Diphtheria/Pertussis) Vaccine since August 2012</strong></td>
<td>M/ D / Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Varicella (Chicken Pox)</strong> Two (2) doses after age 12 months, given at least 28 days apart. A blood test report indicating immunity is acceptable.</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Immunizations after age 16

<table>
<thead>
<tr>
<th>Immunization</th>
<th>1st Dose Date</th>
<th>2nd Dose Date</th>
<th>3rd Dose Date</th>
<th>Booster Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. Meningitis – Serogroup A,C,Y, W135</strong> Menactra, Menveo or Menomune Must be at least one dose administered after age 16.</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>7. Meningitis – Serogroup B</strong> - Please indicate which brand received. Minimum of two doses are required.</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td>M/ D / Y</td>
<td></td>
</tr>
<tr>
<td>□ Bexsero or □ Trumenba</td>
<td></td>
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</tbody>
</table>

**COVID-19**

COVID-19 - Please indicate which brand received. 
- □ Moderna □ Pfizer □ Johnson & Johnson □

### REQUIRED IMMUNIZATIONS

**Other Immunizations Received** (not required):

<table>
<thead>
<tr>
<th>Immunization</th>
<th>1st Dose Date</th>
<th>2nd Dose Date</th>
<th>3rd Dose Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV (Human Papillomavirus Vaccine)</td>
<td></td>
<td></td>
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<tr>
<td>Pneumococcal</td>
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<tr>
<td>Typhoid Oral</td>
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<td></td>
<td></td>
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<tr>
<td>Typhoid IM</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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</tr>
</tbody>
</table>
PHYSICAL EXAMINATION MUST BE COMPLETED ON THIS FORM

PART IV — PHYSICAL EXAMINATION PAGE 1 OF 2

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. _____/_____/_____

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD / ADHD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Arythmia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celiac Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitis</td>
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</tr>
</tbody>
</table>

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

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 AND ALLERGIES:

COVID-19 Yes □ No □ High Cholesterol Yes □ No □ Heart Murmur Yes □ No □ Sickle Cell Disease Yes □ No □ Rheumatoid Arthritis (or JIA) Yes □ No

ADD / ADHD Yes □ No □ Head Injury / Concussion Yes □ No □ Hypertension Yes □ No □ Seizure Disorder Yes □ No

Anemia Yes □ No □ Heart Infarction Yes □ No □ Skin Condition (Please Specify) Yes □ No

Asthma Yes □ No □ Heart Infection Yes □ No □ Syncope Yes □ No

Cardiac Arythmia Yes □ No □ Headache Disorder Yes □ No □ Thyroid Disorder Yes □ No

Celiac Disease Yes □ No □ Headache Disorder Yes □ No □ Type 1 Diabetes Yes □ No

COVID-19 Yes □ No □ Heart Infarction Yes □ No □ Type 2 Diabetes Yes □ No

Diabetes Mellitus Yes □ No □ Headache Disorder Yes □ No □ Uremia Yes □ No

Provide details for any YES Answers:

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

THIS SECTION IS REQUIRED FOR VARSITY ATHLETIC PARTICIPATION

*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: ___________________________________________  For Provider’s Stamp

Office Phone: _____________________________________________  __________________________

Office Fax: _______________________________________________
**TUBERCULIN QUESTIONNAIRE**

**US RESIDENTS**

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.

<table>
<thead>
<tr>
<th><strong>Tuberculin Skin Test (TST)</strong></th>
<th><strong>Date of Test:</strong> _______________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signature of Provider Testing:</strong></td>
<td>_______________</td>
</tr>
<tr>
<td><strong>Date of Reading:</strong> _______________</td>
<td></td>
</tr>
<tr>
<td><strong>Signature of Provider Reading Test:</strong></td>
<td>_______________</td>
</tr>
</tbody>
</table>

- **Negative** ______ mm  
- **Positive** ______ mm

**NON-US RESIDENT**  
*(this includes dual citizenship)*

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.

<table>
<thead>
<tr>
<th><strong>QuantiFERON Gold Test</strong></th>
<th><strong>Date of Test:</strong> _______________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Treatment</strong></td>
<td>_______________</td>
</tr>
<tr>
<td><strong>Date of Treatment</strong></td>
<td>_______________</td>
</tr>
</tbody>
</table>

- **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**

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  [X] 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: ____________________________

* 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  [X] 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 ______ / ______ / ______ to ______ / ______ / ______ . (‘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.

- [ ] My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released.

- [ ] My evaluation, testing, diagnosis or treatment concerning my inpatient or involuntary mental health/rehabilitation treatment may be released.

- [ ] 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.
BU I.D. _________________________
DOB __ / __ / __

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
Is your insurance carrier contracted with UPMC? ☐ No  ☐ Yes

Please place copies of the front and back of your insurance card below.

*Please provide copies of any additional health insurance coverage.*