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

Bucknell UNIVERSITY | Student Health

## 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 | ○____________ |

| GENDER IDENTITY (PLEASE CHECK) | | |
|---|---|---|
| ○Male | ○Gender-queer | ○____________ |
| ○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 and Throat | | | |
| 2. Respiratory | | | |
| 3. Cardiovascular | | | |
| 4. Gastrointestinal | | | |
| 6. Genitourinary | | | |
| 7. Musculoskeletal | | | |
| 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: ______________________________

______________________________________________________________

## REQUIRED IMMUNIZATIONS

**Tdap (Tetanus, Diphtheria and Pertussis)** vaccine since **August 2012**. 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 Dates ____________________ ____________________

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

Vaccine Dates ____________________ ____________________

## STRONGLY RECOMMENDED IMMUNIZATIONS

**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 ____________________

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

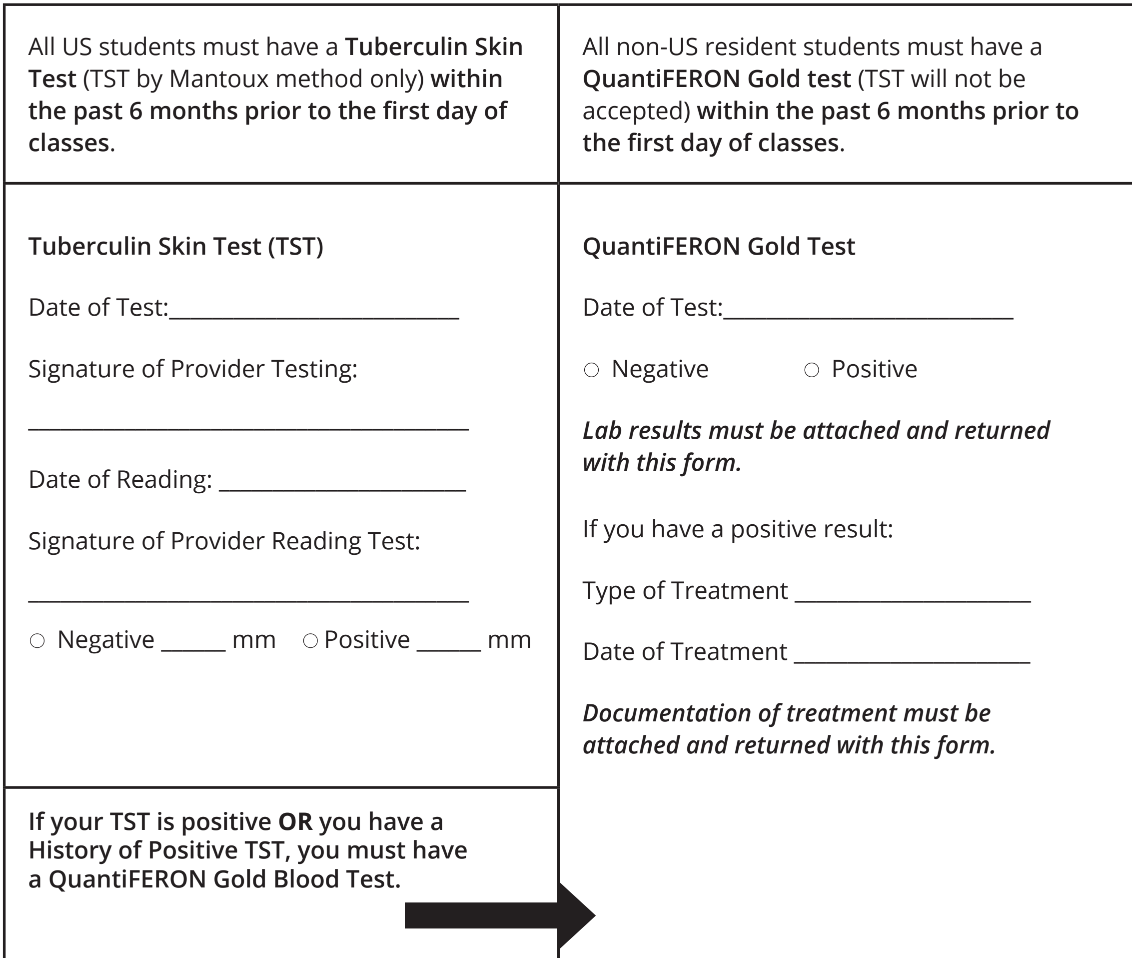
Geisinger

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

## 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 ○____________________ |

### 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.*

## COVID-19 VIRUS 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 ____________________

**Are you an athlete?** ○ Yes ○ No

If yes, please list which sport: ____________________

**Have you had a Covid-19 vaccination?** ○ Yes ○ No

If yes, what date were you immunized? ____________________

Which brand did you receive? ____________________

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**. Please also bring a copy of your positive COVID-19 test result along with you when you come to campus.

After you complete your isolation period of at least 10 days, you will need to contact your home Primary Care Physician (PCP) and request a Medical Clearance Letter containing all of the following:

- Written documentation stating you have completed current CDC isolation criteria measures for at least 10 days from the date of your positive test result —AND—
- You are not currently having any symptoms associated with COVID-19 and are no longer infectious/contagious —AND—
- You are medically cleared to come to campus

The letter can either be faxed to 570-577-3570 or emailed to **medicalrecords@bucknell.edu**. Please also bring a copy of the Medical Clearance Letter along with you when you come to campus.