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 **VARSITY ATHLETES** will be sent an additional **ATHLETIC MEDICAL FORM** that also must be completed and returned to the **ATHLETIC DEPARTMENT**.*

*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 after 8:30 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
REDEFINING BOUNDARIES

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Rev. 4/20/16

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** Complete (with the assistance of your physician, if necessary) all information requested on the form. **DO NOT enclose a separate immunization sheet**.

REQUIRED IMMUNIZATIONS:

1) Hepatitis B: A 3-shot series is required. The first of three (3) 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.) A blood test showing immunity will be acceptable by providing lab reports.

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 lease 28 days apart after 12 months of age and since 1981 are required. 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) Meningitis (Meningococcal vaccine – A,C,Y, W-135): you must either check the box indicating you have had the vaccine **since August 2013 and enter the date of the vaccine** **OR** check the box indicating you have declined the vaccine. The student's signature (or parent/legal guardian's signature if the student is under age 18) is required no matter which box is checked. Meningitis B vaccine is not required but is recommended.

4) Polio (OPV or IPV): Dates of basic series and last booster (administered at least one year following completion of basic series and after age 4).

5) Tetanus/Diphtheria/Pertussis (TDAP) or Booster: A TDAP vaccine **since August 2006** is required. TDAP may be administered regardless of interval since the last tetanus or diphtheria toxoid-containing vaccine.

6) Chicken Pox (Varicella): Requirement is: history of having the disease; or 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.

E. **PART IV – PHYSICAL EXAMINATION** Arrange for a physical examination (requirement is for a physical **within one year prior to your first day of class at Bucknell**) and have PART IV completed and signed by the physician or medical provider after reviewing the immunization requirements listed above. **PLEASE SHOW THIS INSTRUCTION SHEET TO YOUR PHYSICIAN OR MEDICAL PROVIDER**.

F. **PART V – TUBERCULOSIS SCREENING QUESTIONNAIRE** Page 1 to be completed by student and reviewed by Medical Provider. Provider to complete and sign Part V Page 2 **only** if student answered yes to Part V Section B. Part V Page 2 – TST interpretation should be based on mm of induration as well as risk factors.

G. **INSURANCE INFORMATION –** Complete the form and attach a copy, front and back, of your health insurance cards.

H. 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 your 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 — STUDENT

Year of entrance _____ Admitted as a ☐First-Year ☐Transfer ☐Graduate ☐Other BU ID#_____

PLEASE *PRINT* NAME LEGIBLY IN INK

FULL NAME OF STUDENT _____
Last Name First Name Middle Name

HOME ADDRESS _____
Street Address

_____
City State / Zip Code

Student Cell Phone (_____) _____ Home Phone (_____) _____ D.O.B. _____/_____/_____
Month Day Year

Parent/Guardian Cell Phone (_____) _____

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?			
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.			

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 your dorm room key.
Please record dates (month/day/year) below – **Do NOT enclose a separate immunization sheet.**

NAME _____
Last First Middle

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

REQUIRED IMMUNIZATIONS

	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 showing immunity is acceptable.	/ /	/ /	/ /	
2. **MMR** (Measles/Mumps/Rubella) Two (2) doses after age 12 months, given at least 28 days apart, and since 1981. Blood test reports indicating immunity are acceptable.	/ /	/ /		
3. **MENINGITIS – Please check the statement that applies and sign:** _____ I have received the meningitis vaccine (Serogroup A,C,Y, W135) (Menactra, Menveo or Menomune **since August 2013.** **Vaccine Date** _____/_____/_____. _____ I have read and understand the information about meningitis, and I decline the A,C,Y, W135 meningitis vaccine or meningitis booster vaccine at this time. I understand that if I decide in the future that I want the vaccine, I can receive it at Bucknell Student Health. _____ Date *Student's Signature or Parent's Signature if student is under age 18 or not yet graduated from high school*				
4. **Polio (OPV or IPV)** Basic series of three doses and last booster (at least one year following completion of basic series) and **after age four**.	/ /	/ /	/ /	/ /	/ /
5. **TDAP** (Tetanus/Diphtheria/Pertussis) Vaccine **since August 2006**	/ /			
6. **Varicella (Chicken Pox)** **Two doses required** **OR** History of having the disease, vaccine, or blood test report indicating immunity by providing laboratory report is acceptable. **History of Disease date**	/ /	/ /		
	/ /			

OTHER IMMUNIZATIONS RECEIVED (not required):	1st Dose Date	2nd Dose Date	3rd Dose Date
Hepatitis A			
HPV (Human Papillomavirus Vaccine			
Meningitis - Serogroup B (New Vaccine):			
Bexsero			
Trumenba			
Pneumococcal:			
Typhoid Oral			
Typhoid IM			
Other:			

TUBERCULOSIS SCREENING – SEE SEPARATE FORM

PART IV — PHYSICAL EXAMINATION

PHYSICIAN

Physical examination acceptable only if done within one (1) year prior to your first day of class at Bucknell

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

NAME _____
Last First Middle

BP _____ PULSE _____ HT _____ WT_____ BMI _____

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

BIRTH GENDER
Male _____
Female _____
Intersex _____

PREFERRED PRONOUN
He _____
She _____
Other _____

Current medications, dosages and frequencies: _____

_____

_____

Allergies to medication: _____

Allergies to food or environment: _____

Are there abnormalities of the following systems? Describe fully.

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

Has the patient ever been diagnosed for any psychiatric or mental health condition? No_____ Yes_____ Explain: _____

_____

Has the patient ever been diagnosed with ADD/ADHD? No_____ Yes_____

Is there a history of eating disorders? No_____ Yes_____ Explain: _____

_____

General comments/recommendations: _____

_____

I certify that to the best of my knowledge the information provided on PART IV of this form is true and complete. _____
Initial

Date _____ Provider's Signature _____

Address _____
Street City State/Zip

Telephone: (_____) _____

Fax: (_____) _____

For Provider's Stamp

Bucknell Student Health
Tuberculosis (TB) Screening Questionnaire

PART V

PAGE 1 → TO BE COMPLETED BY STUDENT AND REVIEWED BY MEDICAL PROVIDER.

Student Name: _____ DOB _____/_____/_____
(PLEASE PRINT) Last Name First Name M.I.

1. Have you had a previous **positive** TB Skin Test ☐ No ☐ Yes *or*

2. Have you had a previous **positive** IGRA Blood Test? ☐ No ☐ Yes

3. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ No ☐ Yes

4. Were you born in one of the countries listed below that have a high incidence of active TB disease? ☐ No ☐ Yes
(If yes, please **CIRCLE** the country, below)

Afghanistan	Republic	Guam	Malawi	Portugal	Thailand
Algeria	Chad	Guatemala	Malaysia	Qatar	The former
Angola	China	Guinea	Maldives	Republic of Korea	Yugoslav Republic
Argentina	Colombia	Guinea-Bissau	Mali	Republic of	of Macedonia
Armenia	Comoros	Guyana	Marshall Islands	Moldova	Timor-Leste
Azerbaijan	Congo	Haiti	Mauritania	Romania	Togo
Bahrain	Côte d'Ivoire	Honduras	Mauritius	Russian Federation	Tunisia
Bangladesh	Croatia	India	(Federated States	Rwanda	Turkey
Belarus	Democratic People's	Indonesia	of) Micronesia	Saint Vincent and	Turkmenistan
Belize	Republic of Korea	Iraq	Mongolia	the Grenadines	Tuvalu
Benin	Democratic	Japan	Morocco	Sao Tome and	Uganda
Bhutan	Republic of the	Kazakhstan	Mozambique	Principe	Ukraine
Bolivia	Congo	Kenya	Myanmar	Senegal	United Republic of
(Plurinational State	Djibouti	Kiribati	Namibia	Seychelles	Tanzania
of) Bosnia and	Dominican Republic	Kuwait	Nepal	Sierra Leone	Uruguay
Herzegovina	Ecuador	Kyrgyzstan	Nicaragua	Singapore	Uzbekistan
Botswana	El Salvador	Lao People's	Niger	Solomon Islands	Vanuatu
Brazil	Equatorial Guinea	Democratic	Nigeria	Somalia	Bolivarian Republic
Brunei Darussalam	Eritrea	Republic	Pakistan	South Africa	of Venezuela
Bulgaria	Estonia	Latvia	Palau	Sri Lanka	Viet Nam
Burkina Faso	Ethiopia	Lesotho	Panama	Sudan	Yemen
Burundi	Fiji	Liberia	Papua New Guinea	Suriname	Zambia
Cambodia	Gabon	Libyan Arab	Paraguay	Swaziland	Zimbabwe
Cameroon	Gambia	Jamahiriya	Peru	Syrian Arab	
Cape Verde	Georgia	Lithuania	Philippines	Republic	
Central African	Ghana	Madagascar	Poland	Tajikistan	

5. Have you had frequent or prolonged visits* (more than 4 weeks) to one or more of the countries listed above with a high prevalence of TB disease? (If yes, **CIRCLE** the countries, above) ☐ No ☐ Yes

6. Have you been a volunteer or employee of a hospital, nursing home, or health clinic? ☐ No ☐ Yes

7. Have you been a resident, employee, or volunteer at high-risk congregate settings (e.g., correctional facilities, long-term care facilities and homeless shelters)? ☐ No ☐ Yes

If the answer is YES to any of the above questions, Bucknell University requires that your Health Care Provider complete Part V Page 2

If the answer to all of the above questions is NO and you were not born or traveled to a country listed above, no further testing or action is required and you do not need to have your Health Care Provider complete Part V, Page 2.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

PART V

Bucknell Student Health Required Tuberculosis (TB) Screening

PAGE 2 → TO BE COMPLETED ONLY IF STUDENT ANSWERED YES TO ANY OF THE QUESTIONS ON PART V PAGE 1

Student Name: _____ DOB _____/_____/_____
(PLEASE PRINT) Last Name First Name M.I.

MEDICAL PRACTITIONER:

- Screening must be done within 12 months of the first day of classes.
- A student who has any positive risk factors must be tested for TB infection if there is no written documentation of a previous positive tuberculin skin test (TST) or positive Interferon gamma release assay (IGRA) (e.g. T-Spot, Quantiferon Gold).
- Previous BCG Immunization does not change TB screening requirements.

TB Symptom Check Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ No ☐ Yes

❏ Cough (especially if lasting for 3 weeks longer) with or without sputum production
❏ Coughing up blood (hemoptysis) ❏ Unexplained weight loss
❏ Chest pain ❏ Night sweats
❏ Loss of appetite ❏ Fever

REQUIRED

Tuberculin Skin Test (TST)**
**www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
Date Given: ____/____/____ Date Read: ____/____/____
Result: _____ mm of induration
**Interpretation: positive____ negative____

OR

Interferon Gamma Release Assay (IGRA)
Date Obtained: ____/____/____ (QFT-GIT, T-Spot)
Result: negative___ positive___ indeterminate___
borderline___ (T-Spot only)

IF POSITIVE

Chest x-ray (Required if TST or IGRA is positive)
Date Obtained: ____/____/____
Result: normal ____ abnormal ____

Provide proof of treatment given for positive TB testing:	Medication _____ Date Treatment Started _____ Date Treatment Completed _____

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Provider Signature _____ Title _____ Date _____

Address _____ Phone _____ Fax _____

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 box.

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.*

Student Name: _____
(PLEASE PRINT) Last Name First Name M.I.

BU I.D. _____

DOB _____/_____/_____

BIRTH GENDER
Male _____
Female _____
Intersex _____

PREFERRED PRONOUN
He _____
She _____
Other _____

Subscriber Information

Subscriber's Name: _____ DOB _____/_____/_____

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 or 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