Bucknell UNIVERSITY | Student Health

Bucknell Student Health Provider Packet

First Year, Transfer students, Summer Students, Grad/ Non-Degree using us as their Medical Provider

- ☐ Print Packet
- ☐ Take entire packet to Doctors office
- ☐ Complete the Physical form on our packet. Attachments will not be accepted.
- ☐ Immunization form needs to be filled out. Please also attach a print out from your doctor's office.
- ☐ Complete Tuberculin skin test / QuantiFERON gold test
- ☐ Upload and submit entire packet for review
- ☐ Make sure Demographic page is completed and submitted for review
- ☐ Make sure Insurance page is completed and submitted for review
- ☐ Be sure to check your Bucknell email for additional information

Grad / Non-degree Students - Not using Student Health as their medical provider

You will need to submit the Tuberculin skin test and Immunization sheet. You do not need to complete a physical form unless you plan to use Student Health as your medical provider.

- ☐ Print packet
- ☐ Complete Immunization form. Please also attach a print out from your doctor's office.
- ☐ Complete Tuberculin skin test / QuantiFERON gold test
- ☐ Upload and submit packet for review
- ☐ Make sure Demographic page is completed and submitted for review
- ☐ Make sure Insurance page is completed and submitted for review
- ☐ Be sure to check your Bucknell email for additional information

Geisinger

EVANGELICAL COMMUNITY HOSPITAL
Excellence Every Day.

A Joint Venture of Evangelical-Geisinger Health, LLC

TUBERCULIN SKIN TEST

Mantoux skin test / PPD

Completing and returning this form are requirements for admission

Name: _____ Date of Birth: _____

BU ID: _____

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.*	

** All positive QuantiFERON gold results must either have been treated or agree to treatment in order to stay enrolled.

IMMUNIZATION RECORDS

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. Medical records deadline is June 15th for fall semester.

NAME _____ D.O.B ____ / ____ / ____
Last First Middle 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
Hepatitis B A 3-shot series is required and must have been given prior to enrollment at Bucknell. (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.)				
MMR (Measles/Mumps/Rubella) 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 the disease diagnosed is not sufficient).**				
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 report indicating immunity is acceptable).				
Tdap (Tetanus/Diphtheria/Pertussis) Vaccine **since August 2014**				
Varicella (Chicken Pox) 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 disease diagnosed is not sufficient).**				
Meningitis – Serogroup A,C,Y, W135 (Menactra, Menveo or Menomune) **Must be at least one dose administered after age 16.**				
Please note: Both Meningitis and Meningitis B are both required Immunizations				
Meningitis – Serogroup B – Minimum of two doses are required Please indicate which brand received. ☐ **Bexsero** ☐ **Trumenba** Dosing schedule varies by vaccination brand.				

OTHER IMMUNIZATIONS RECEIVED (not required but strongly recommended):	1st Dose Date	2nd Dose Date	3rd Dose Date
COVID-19 - ☐ Moderna ☐ Pfizer ☐ J&J ☐ _____			
HPV (Human Papillomavirus Vaccine)			
OTHER IMMUNIZATIONS RECEIVED - (not required)			
Hepatitis A			
Pneumococcal			
Typhoid ☐ **Oral** ☐ **IM**			
Other:			

PHYSICAL EXAMINATION MUST BE COMPLETED ON THIS FORM

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. Medical provider packets for fall semester are due by June 15th.

Name: _____ Date of Birth: ____/ ___ / ____
Last First Middle

Current prescription and nonprescription medication(s) with **dosage(s)**: ○No ○Yes, please list:_____
_____

Medication Allergies: ○No ○Yes, List _____
Food Allergies: ○No ○Yes, List _____
Environmental Allergies: ○No ○Yes, List _____
History of Anaphylaxis: ○No ○Yes, what was the trigger? _____
Does the 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			
Musculoskeletal			
Neurological			# of concussions
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? ○No ○Yes
Has the patient ever been diagnosed with ADHD? ○No ○Yes
Is there any history of an eating disorder? ○No ○Yes, Explain: _____
_____
General comments/recommendations: _____

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

Date of Physical Examination: _____

Physician/Healthcare Provider's Signature _____ MD, DO, NP, PA-C
Office Address: _____ ***PROVIDER'S STAMP***
_____
Office Phone: _____
Office Fax: _____