This form must be printed, completed in its entirety and the original sent to:

LEHIGH UNIVERSITY
Health & Wellness Center
36 University Drive, Johnson Hall
Bethlehem, PA 18015

No later than June 15 for Fall enrollment or January 1 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 UNDERGRADUATE STUDENTS are required to enroll or waive the Lehigh University Health Insurance plan on-line.

During the summer months, inquiries regarding the medical record are received weekday mornings after 8:00 a.m. at 610-758-3870.
DIRECTIONS FOR PREPARING AND RETURNING
THE LEHIGH STUDENT HEALTH MEDICAL RECORD

A. DEMOGRAPHICS PRINT CAREFULLY IN INK, also PRINT your name on all pages where indicated.

B. PART I – MEDICAL HISTORY Ask your parents, guardian, or healthcare provider to assist in completing this section.

C. PART II – CONSENT FOR TREATMENT SIGN and DATE.

D. PART III – IMMUNIZATION RECORD Once completed and signed by your healthcare provider you must enter your dates of vaccines on-line in the patient portal. After entering information on-line, completed forms NEED to be mailed to the Health & Wellness Center in order to verify immunization compliance.

REQUIRED IMMUNIZATIONS:

1) **Hepatitis B**: A 3-shot series is required. The first of three (3) must have been given prior to enrollment at Lehigh. 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 least 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 after age 16 and enter the date of the vaccine OR check the box indicating you have declined the vaccine.

AND

Meningitis (Meningococcal vaccine – Serogroup B): you must either check the box indicating you have had 2 or 3 doses of the vaccine and enter the dates of the vaccine OR check the box indicating you have declined the vaccine.

OPTIONS AVAILABLE
- **Bexsero**: Two (2) dose series administered at least one month apart.
- **Trumenba**: Three (3) dose schedule administered at 0, 1-2, and 6 months; or Two (2) dose schedule administered at 0 and 6 months.

Both student and parent(s) should review *Meningococcal Disease Information* enclosed. The student’s signature is required no matter which boxes are checked.

4) **Polio (OPV or IPV)**: Last booster after age 4.

5) **Tetanus/Diphtheria/Pertussis (Tdap) or Booster**: A Tdap vaccine within 10 years 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 An exam is recommended for all students. VARSITY ATHLETES are REQUIRED to have a physical within 6 months prior to your first day of class at Lehigh. PART III and/or PART IV should be completed and signed by the physician or healthcare provider after reviewing immunization requirements listed above. PLEASE SHOW THIS INSTRUCTION SHEET TO YOUR PHYSICIAN OR HEALTHCARE PROVIDER.

F. TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE The on-line screening questionnaire needs to be completed by ALL students by logging into the patient portal. Testing for TB is only required if student is identified as having increased risk, individuals will be contacted if testing indicated.

G. Return the entire completed medical form to Lehigh University Health & Wellness Center no later than June 15 for Fall enrollment or January 1 for Spring enrollment. PLEASE BE ADVISED THAT YOU MAY NOT BE ABLE TO OBTAIN YOUR DORM ROOM KEY IF YOUR MEDICAL RECORD IS NOT RECEIVED OR IS INCOMPLETE.
This form must be completed in its entirety and the original sent to LEHIGH UNIVERSITY Health & Wellness Center no later than June 15 for Fall enrollment or January 1 for Spring enrollment. Failure to comply may prevent student from obtaining their dorm room key.

During the summer months, inquiries regarding the medical record are received weekday mornings after 8:00 a.m. at 610-758-3870.

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**DEMOGRAPHICS**

Year of entrance __________ ( ) First-Year ( ) Graduate ( ) Other __________

LU ID# ___________________________ D.O.B. _______/_____/______

Month Day Year

FULL NAME OF STUDENT

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

HOME ADDRESS

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State / Zip Code</th>
</tr>
</thead>
</table>

Student Cell Phone ( _____ ) __________________________

Parent/Guardian: __________________________ Cell Phone ( _____ ) __________________________

Parent/Guardian: __________________________ Cell Phone ( _____ ) __________________________

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**PART I — MEDICAL HISTORY**

<table>
<thead>
<tr>
<th>Student</th>
<th>No</th>
<th>Yes (specify)</th>
<th>Remarks or additional information (use additional sheet if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you presently being treated for any condition(s), i.e. Diabetes, Crohn’s?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had any surgery?</td>
<td></td>
<td>What? When?</td>
<td></td>
</tr>
<tr>
<td>Do you have a history of asthma?</td>
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</tr>
<tr>
<td>Do you have a history of mono?</td>
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<tr>
<td>Have you been diagnosed with ADD/ADHD?</td>
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<tr>
<td>Have you ever received treatment for any psychiatric, mental health, disordered eating or psychological condition? Explain.</td>
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**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 Lehigh University Health & Wellness Center staff.
- I am aware of the Notice of Privacy Practices available at: [www.lehigh.edu/health/mission.shtml#privacy](http://www.lehigh.edu/health/mission.shtml#privacy)
- 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 Lehigh University Health & Wellness Center, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.
- I understand that my contacts with Lehigh University Health & Wellness Center are held in confidence, but that confidentiality may be broken if my life or that of another person is in danger.

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 – Please attach a copy of full immunization record if available.

**NAME**

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

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

### REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th></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>Hepatitis B</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 3-shot series is required. First of 3 must have been given prior to enrollment at Lehigh. A blood test report showing immunity is acceptable. Please attach report.</td>
<td></td>
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</table>

| **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. Please attach report. |               |               |               |              |

### MENINGITIS – Please initial the statements that apply and sign:

- I HAVE RECEIVED the meningitis vaccine (Serogroup A,C,Y, W135) Menactra, Menveo or Menomune after age 16. 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.

**AND**

- I HAVE RECEIVED the meningitis vaccine (Serogroup B) Bexsero 1st dose / / / 2nd dose / / / .

- OR Trumenba 1st dose / / / 2nd dose / / / 3rd dose / / / .

- I have read and understand the information about meningitis, and I DECLINE the serogroup B meningitis vaccine at this time.

**Date** ______________________  **Student’s Signature** ______________________________________________________

**or Parent’s Signature if student is under age 18 or not yet graduated from high school**

I understand that if I decide in the future that I want the vaccine(s), I can receive them at Lehigh University Health & Wellness Center.

### Polio (OPV or IPV)

Last booster after age four.

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</table>

### Tdap (Tetanus/Diphtheria/Pertussis) Vaccine, Adacel or Boostrix, within 10 years.

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### Varicella (Chicken Pox)

Two doses required

- History of having the disease or blood test report indicating immunity by providing laboratory report is acceptable. Please attach report.

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</thead>
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### I certify that to the best of my knowledge the information provided on PART III of this form is true and complete.

**Date** ______________________  **Healthcare Provider’s Signature** ________________________________

**Telephone:** (___________) ____________________  **Fax:** (___________) ________________________________

### OTHER IMMUNIZATIONS RECEIVED (not required):

- **Hepatitis A - 2 doses**

- **HPV (Human Papillomavirus-Gardasil) - 2 or 3 doses**

- **Influenza**

- **Pneumococcal (Prevnar)**

- **Other:**

- **Other:**
PART IV — PHYSICAL EXAMINATION

Physical examination acceptable for ATHLETES only if done within six (6) months prior to your first day of class at LEHIGH

To the examining healthcare provider: Please review the student’s history and complete Part IV. Please comment on all positive answers.

NAME __________________________

Last ______ First ______ Middle ______

D.O.B. ______ / ______ / ______

Examination Date: ______ / ______ / ______

Month Day Year

BP ___________ PULSE ___________ HT ___________ WT ___________ BMI ___________

Current medications, dosages and frequencies: ______________________________________________________________________

________________________________________________________________________________________________________________________________________

Allergies to medication: ___________________________________________________________________________________________

Allergies to food or environment: ___________________________________________________________________________________

Carries an epi-pen? ( ) YES ( ) NO

Are there abnormalities of the following systems? Describe fully.

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Comments (use additional sheet if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Eyes, Ears, Nose or Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Respiratory</td>
<td></td>
<td></td>
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<tr>
<td>3. Cardiovascular</td>
<td></td>
<td></td>
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<tr>
<td>4. Gastrointestinal</td>
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<tr>
<td>5. Genitourinary</td>
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<tr>
<td>6. Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Metabolic/Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Neurologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Concussion (if yes, how many?)</td>
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<tr>
<td>10. Skin</td>
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<td></td>
</tr>
</tbody>
</table>

Has the patient ever been diagnosed with ADD/ADHD or any psychiatric/mental health condition?  No____ Yes____

Explain: __________________________________________________________________________

History of eating disorders?  No____ Yes____

Explain: __________________________________________________________________________

Surgical History?  No____ Yes____

Explain: __________________________________________________________________________

VARSIY ATHLETES: This student has been tested for sickle cell trait and documentation of test results are included: ( ) YES ( ) NO

This student is medically cleared for sports participation: ( ) YES ( ) NO

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

Date________________________

Healthcare Provider’s Signature______________________________________________________

Address _________________________________________________________________________________

Telephone: (_______) _________________________________  Fax: (_______) _________________________________

COMPLETED FORMS CAN BE MAILED OR FAXED TO:
LEHIGH UNIVERSITY Health & Wellness Center
36 University Drive, Johnson Hall
Bethlehem, PA 18015
Phone: 610-758-3870
Fax: 610-758-5833