LEHIGH UNIVERSITY

Student Health Medical Forms

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 residence hall key upon arrival**.

Please keep a copy of this completed form for your records.

*All **STUDENTS** are required to **enroll or waive** the Lehigh University Health Insurance plan .*

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

LEHIGH UNIVERSITY

Health & Wellness Center
36 University Drive
Bethlehem, PA 18015
Phone: 610-758-3870
Fax: 610-758-5833

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 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 **list the date of vaccine(s).** You must have had **at least one vaccine after age 16**.

4) Meningitis (Meningococcal vaccine – Serogroup B)
You must **have had at least 1 dose** prior to enrollment at Lehigh and completion of series within 6 months per manufacturer guidelines. Failure to complete series will result in a HOLD being placed on future class registration.

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.

5) Polio (OPV or IPV)
Basic series of three doses and **last booster after age 4**.

6) 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.

7) 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 RESIDENCE HALL KEY IF YOUR MEDICAL RECORD IS NOT RECEIVED OR IS INCOMPLETE.**

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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 residence hall key**.

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

Insert Photo Here

DEMOGRAPHICS

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

LU ID#_____ D.O.B. _____/_____/_____
Month Day Year

FULL NAME OF STUDENT _____
Last Name First Name Middle Name

HOME ADDRESS_____
Street Address

_____
City State / Zip Code

Student Cell Phone (_____) _____

Parent/Guardian:_____ Cell Phone (_____) _____

Parent/Guardian:_____ Cell Phone (_____) _____

SEX assigned at birth
- o Male
- o Female
- o Intersex

GENDER: _____

PREFERRED PRONOUNS:
_____
_____

PART I — MEDICAL HISTORY

STUDENT

	No	Yes (specify)	Remarks or additional information (use additional sheet if necessary)
Do you have any allergies to medications?			
Are you currently being treated for any condition(s), i.e. Diabetes, Crohn's?			
Have you ever had any surgery? What? When?			
Do you have a history of asthma?			
Do you have a history of mono?			
Have you been diagnosed with ADD/ADHD?			
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 Lehigh University Health & Wellness Center staff.
- I am aware of the Notice of Privacy Practices.
- 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)

PART III – IMMUNIZATION RECORDS

HEALTHCARE PROVIDER

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall key. Please record dates (month/day/year) below -- **PLEASE attach a copy of full immunization record if available**.

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 Lehigh. A blood test report showing immunity is acceptable. Please attach report.	M/D/Y	M/D/Y	M/D/Y	
2. **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 attach report.	M/D/Y	M/D/Y		
3. **MENINGITIS** (Serogroup A,C,Y, W135) **after age 16.** *Menactra*, *Menveo* or *Menomune*	M/D/Y	M/D/Y		
4. **Meningitis** (Serogroup B) Must be started prior to enrollment at Lehigh.				
Bexsero 2 dose series completed within 2 months.	M/D/Y	M/D/Y		
OR				
Trumenba 2 or 3 dose series completed within 6 months.	M/D/Y	M/D/Y	M/D/Y	
5. **Polio** (OPV or IPV) Basic series of three doses and last booster **after age 4**.	M/D/Y	M/D/Y	M/D/Y	M/D/Y
6. **Tdap** (Tetanus/Diphtheria/Pertussis) *Adacel* or *Boostrix*, **within 10 years.**	M/D/Y			
7. **Varicella** (Chicken Pox) **Two doses required**	M/D/Y	M/D/Y		
OR History of having the disease or blood test report indicating immunity by providing laboratory report is acceptable. **History of Disease date**	M/D/Y			

OTHER IMMUNIZATIONS RECEIVED (not required):

Hepatitis A			
HPV (Human Papillomavirus Vaccine)			
Pneumococcal			
Influenza			

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: (_____)_____

PART IV — PHYSICAL EXAMINATION

HEALTHCARE PROVIDER

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 _____ D.O.B. _____/_____/_____
Last First Middle Month Day Year

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.

	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. Skin			

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:_____
Concussion (if yes, how many?) No___ Yes___ Explain:_____

REQUIRED FOR VARSITY ATHLETIC PARTICIPATION:

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 _____
Street City State/Zip

Telephone: (_____) _____ Fax: (_____)_____

For Provider's Stamp

COMPLETED FORMS CAN BE MAILED OR FAXED TO:
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LEHIGH UNIVERSITY

Meningococcal Disease Information

First year college students residing in residence halls are at increased risk for meningococcal disease, a bacterial infection commonly referred to as *Meningitis*. Meningococcal meningitis is rare, but can be fatal or leave survivors with severe and permanent disabilities, including hearing loss, brain damage, and limb amputation. First year college students living in residence halls have been found to have up to a six-fold increased risk for the disease.

Meningococcal meningitis is caused by the bacterium *Neisseria meningitidis*. This bacterium has many different subtypes or serogroups. Five of these serogroups, A, B, C, Y and W-135, cause almost all the invasive disease seen. Serogroup B has been responsible for the most recent outbreaks on college campuses throughout the United States.

There are 2 types of meningococcal vaccines available in the United States – one type protects against **serogroups A, C, Y and W-135** and the other type protects against **serogroup B**. *There is no single vaccine that protects against all 5 serogroups*.

- Meningococcal Conjugated Vaccines for serogroups A, C, Y and W-135 are currently marketed under the name *Menactra* and *Menveo.*
- Meningococcal serogroup B vaccines are marketed under the names *Bexsero* and *Trumenba*.

The CDC recommends vaccination against serogroups A, C, Y and W-135 for students younger than 22 years of age who will reside in residence halls. Students who received their serogroup A, C, Y and W-135 vaccination before the age of 16 require a 2nd vaccination (booster) after their 16th birthday.

The CDC also recommends that college students consider vaccination against Meningococcal serogroup B. The Meningococcal serogroup B series can be administered to persons 16 through 23 years of age with a preferred age of vaccination of 16 through 18 years.

In 2002, Pennsylvania enacted the College and University Student Vaccination Act that requires all students who will reside in campus housing is educated about Meningitis and the benefits of vaccination. ***ALL new Lehigh students who will reside in campus housing must provide documentation of vaccination against meningococcal Meningitis or sign waivers declining the vaccines***. The Lehigh University Health & Wellness Center is fully committed to upholding this statute. Students who are not in compliance with the Pennsylvania College and University Student Vaccination Act will NOT receive their residence hall keys on Move-In Day.

With the arrival of a new vaccine against the B serogroup in 2014, *almost all cases of Meningococcal meningitis are now vaccine preventable*. Adverse reactions to both MCV4 and MenB vaccines are mild and infrequent. As with all vaccines, vaccination against Meningococcal meningitis may not protect 100% of susceptible individuals. The Lehigh University Health & Wellness Center carries the MCV4 and both MenB vaccines and is able to provide those vaccines to students beginning any time prior to arrival on campus.