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

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

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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.*

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

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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 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.
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.

### DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Year of entrance</th>
<th>( ) First-Year ( ) Graduate ( ) Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>LU ID#</td>
<td>D.O.B. Month / Day / Year</td>
</tr>
<tr>
<td>Full Name of Student</td>
<td>Last Name</td>
</tr>
<tr>
<td>Home Address</td>
<td>Street Address</td>
</tr>
<tr>
<td>Student Cell Phone ( )</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian:</td>
<td>Cell Phone ( )</td>
</tr>
<tr>
<td>Parent/Guardian:</td>
<td>Cell Phone ( )</td>
</tr>
</tbody>
</table>

### STUDENT

<table>
<thead>
<tr>
<th>PART I — MEDICAL HISTORY</th>
<th>Remarks or additional information (use additional sheet if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any allergies to medications?</td>
<td>Yes (specify)</td>
</tr>
<tr>
<td>Are you currently being treated for any condition(s), i.e. Diabetes, Crohn's?</td>
<td></td>
</tr>
<tr>
<td>Have you ever had any surgery? What? When?</td>
<td></td>
</tr>
<tr>
<td>Do you have a history of asthma?</td>
<td></td>
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<tr>
<td>Do you have a history of mono?</td>
<td></td>
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<tr>
<td>Have you been diagnosed with ADD/ADHD?</td>
<td></td>
</tr>
<tr>
<td>Have you ever received treatment for any psychiatric, mental health, disordered eating or psychological condition? Explain.</td>
<td></td>
</tr>
</tbody>
</table>

### 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.
- 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

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

<table>
<thead>
<tr>
<th>Immunization</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>1. Hepatitis B</strong></td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td>M / D / Y</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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<td></td>
</tr>
<tr>
<td><strong>2. MMR (Measles/Mumps/Rubella)</strong></td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two (2) doses after age 12 months, given at least 28 days apart. Blood test reports indicating immunity are acceptable. Please attach report.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>3. MENINGITIS (Serogroup A,C,Y, W135) after age 16.</strong></td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td></td>
<td></td>
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<tr>
<td>Menactra, Menveo or Menomune</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>4. Meningitis (Serogroup B)</strong></td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td></td>
<td></td>
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<tr>
<td>Must be started prior to enrollment at Lehigh.</td>
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<tr>
<td><strong>Bexsero</strong></td>
<td>2 dose series completed within 2 months.</td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td></td>
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<tr>
<td><strong>OR</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Trumenba</strong></td>
<td>2 or 3 dose series completed within 6 months.</td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td>M / D / Y</td>
</tr>
<tr>
<td><strong>5. Polio (OPV or IPV)</strong></td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td>M / D / Y</td>
</tr>
<tr>
<td>Basic series of three doses and last booster after age 4.</td>
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<tr>
<td><strong>6. Tdap (Tetanus/Diphtheria/Pertussis) Adacel or Boostrix, within 10 years.</strong></td>
<td>M / D / Y</td>
<td></td>
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<tr>
<td><strong>7. Varicella (Chicken Pox)</strong></td>
<td>M / D / Y</td>
<td>M / D / Y</td>
<td></td>
<td></td>
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<tr>
<td>Two doses required</td>
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<td></td>
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<tr>
<td><strong>OR</strong></td>
<td></td>
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<tr>
<td>History of having the disease or blood test report indicating immunity by providing laboratory report is acceptable.</td>
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<tr>
<td><strong>History of Disease date</strong></td>
<td>M / D / Y</td>
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</tbody>
</table>

#### 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**

*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>System</th>
<th>No</th>
<th>Yes</th>
<th>Comments (use additional sheet if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Eyes, Ears, Nose or Throat</td>
<td></td>
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<tr>
<td>Respiratory</td>
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<td>Cardiovascular</td>
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<td>Gastrointestinal</td>
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<td>Genitourinary</td>
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<td>Musculoskeletal</td>
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<tr>
<td>Metabolic/Endocrine</td>
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<tr>
<td>Neurologic</td>
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<td></td>
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<tr>
<td>Skin</td>
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</tr>
</tbody>
</table>

Has the patient ever been diagnosed with ADD/ADHD or any psychiatric/mental health condition? ( ) YES ( ) NO

Explain: ________________________________________________________________

History of eating disorders? ( ) Yes ( ) No

Explain: ________________________________________________________________

Surgical History? ( ) Yes ( ) No

Explain: ________________________________________________________________

Concussion (if yes, how many?) ( ) Yes ( ) No

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 ____________________________________________ ____________________________________________

Telephone: (_________) _________________________________ Fax: (__________) _________________________________

**HEALTHCARE PROVIDER**

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
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.