LEHIGH UNIVERSITY

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

Dear Entering Student:

On behalf of the Health Center staff, welcome to Lehigh University.

Enclosed is your immunization and physical examination form which must be completed and uploaded to your Student Health Portal by **July 14th** for Fall Admission or **January 14th** for Spring Admission. This information enables our staff to provide the best possible care for you and is treated confidentially. A physical examination within the last 12 months is required for all incoming students. For students who plan to participate in **varsity athletics**, the physical examination must be within 6 months of your first day of classes at Lehigh.

Communicable diseases continue to cause outbreaks on college campuses. We **require** the following immunizations or evidence of immunity. **Failure to comply may result in registration being blocked for your second semester.** We suggest you bring this letter to your healthcare provider along with your health form.

1. Hepatitis B
   A three (3) shot series is required.
2. Measles Mumps Rubella (MMR)
   Two (2) single doses of live measles, mumps, and rubella vaccine or two (2) combined doses of MMR vaccine at least 28 days apart after 12 months of age are required.
3. Tetanus/Diptheria/Pertussis (Tdap) or Booster
   A Tdap vaccine **within 10 years is required.**
4. Chicken Pox (Varicella)
   Requirement is two (2) doses of vaccine; or blood test report showing immunity.
5. Meningitis (Meningococcal Vaccine – A,C,Y,W-135)
   You must have had **at least one vaccine after the age of 16.**
6. Meningitis B (Meningococcal Vaccine – Serogroup B – Bexsero or Trumenba)
   You must **have had at least 1 dose** prior to enrollment at Lehigh, and completion of series within manufacturer guidelines. If non-compliant, the student will not be able to obtain their residence hall room key.

**For more information on these vaccines, please refer to the CDC website. (www.cdc.gov/vaccines)*

The Health & Wellness Center offers the following vaccines for a fee – HPV (Gardasil 9), Meningitis A,C,Y,W (Menveo), Meningitis B (Bexsero & Trumenba), and Tdap (tetanus, diphtheria, & pertussis).

Please visit our website www.lehigh.edu/health to view a listing of services offered, policies, and our Notice of Privacy Practices. The bursar's office will send you information on the university-sponsored health insurance plan, Wellfleet (a Cigna product) designed to complement the services provided to students by the Health & Wellness Center. We strongly recommend consideration of the plan even if you have other health insurance. It is particularly important for you to understand possible limitations with health insurance while you are attending college, including easy access to simple blood tests and x-rays. We recommend consulting your physician or insurance carrier before waiving the university health insurance. Regardless of your coverage, proof of insurance is required to be uploaded to your student health portal.

Best wishes for a successful and healthy experience at Lehigh!
Sincerely,

Dr. Steven Bowers, DO

Dr. Steven Bowers, DO
Director

Karen Sicinski, BSN

Karen Sicinski, BSN
Director of Nursing

LEHIGH UNIVERSITY **PHYSICAL EXAMINATION** **2023/2024**

*Physical Examination required for **ALL incoming students,** MUST be done **within one (1) year** prior to your first day of class at LEHIGH.*
*Physical Examination required for **ALL varsity athletes,** MUST be done **within six (6) months** prior to your first day of class at LEHIGH.*

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

Examination Date: _____/_____/_____
Month Day Year

Take any medications? If yes, please list med, dose, frequency. ( )NO ( )YES _____

_____

_____

Any allergies (medicine, food, environmental)? ( )NO ( )YES, explain: _____

_____

History of Anaphylaxis? ( )NO ( )YES, what was the trigger? _____ Does student carry an EpiPen or AuviQ? ( )NO ( )YES
MEDICAL HISTORY? _____

_____

_____

SURGICAL HISTORY? _____

_____

Any general comments or recommendations that may be important for the care of this student? _____

_____

_____

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			
Neurologic			# of Concussions _____
Skin			

REQUIRED FOR VARSITY ATHLETIC PARTICIPATION:

NCAA requires confirmation of sickle cell trait status for all DIVISION III athletes, documentation of test results must be provided and uploaded.

This student is medically cleared for sports participation: ( ) Unlimited ( ) Limited ( ) Not Cleared, provide details: _____
_____ ( ) N/A

Please be sure to have this section completed if you plan to participate in varsity sports at any time during your residence here on campus.

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

Physician/Healthcare Provider's Signature_____ MD, DO, NP, PA-C DATE: _____

Office Address: _____

Office Phone: _____

Office Fax: _____

[OFFICE STAMP]

LEHIGH UNIVERSITY | **IMMUNIZATION RECORD** | **2023/2024**

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall room key.
Please record dates (month/day/year) below AND include a copy of vaccine records from your medical provider.

NAME _____
Last First Middle

D.O.B. _____/_____/_____
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
1. **Hepatitis B** A three (3) dose series is required. A blood test report indicating immunity is acceptable.	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. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y	
3. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **within 10 years.**	M/D/Y		
4. **Varicella** (Chicken Pox) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y	
IMMUNIZATONS AFTER AGE 16			
5. **Meningitis** (Serogroup A,C,Y, W135) at least one (1) dose **after age 16.** *Menactra, Menveo or Menomune*	M/D/Y	M/D/Y	
6. **Meningitis B** (Serogroup B) Two (2) doses are required. Please indicate which brand received. ☐ ***Bexsero*** *- 2 dose series (1-2 months apart)* OR ☐ ***Trumenba*** *- 2 dose series (6 months apart)*	M/D/Y	M/D/Y	M/D/Y

OTHER IMMUNIZATIONS RECEIVED (highly recommended *but not required*)

COVID-19 *( )Moderna ( )Pfizer ( )Johnson & Johnson ( )_____*				
Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza				
Polio				

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

Healthcare Provider's Signature _____ Date: _____

Telephone: _____

Fax: _____ [Office Stamp]