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**

**Karen Sicinski, BSN**

Dr. Steven Bowers, DO

Karen Sicinski, BSN

Director

Director of Nursing
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** __________________________

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<thead>
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<th>Last</th>
<th>First</th>
<th>Middle</th>
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D.O.B. _______/_______/_______

**Examination Date: **________/________/________

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/_____

<table>
<thead>
<tr>
<th>Normal</th>
<th>Not Examined</th>
<th>Abnormal - describe findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>General Appearance</td>
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<tr>
<td>Head, Eyes, Ears, Nose, Throat</td>
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<td></td>
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<tr>
<td>Lymph Nodes</td>
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<td>Cardiovascular/Pulses</td>
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<td>Respiratory/Lungs</td>
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<td>Gastrointestinal</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Neurologic</td>
<td></td>
<td># of Concussions ________________</td>
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<tr>
<td>Skin</td>
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</tbody>
</table>

**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: __________________________________________________________________________________________

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]
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**

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

**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.**

<table>
<thead>
<tr>
<th>1st Dose Date</th>
<th>2nd Dose Date</th>
<th>3rd Dose Date</th>
</tr>
</thead>
</table>

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)

**IMMUNIZATIONS 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)

   Please note: Both Meningitis and Meningitis B are required immunizations

6. **Meningitis B (Serogroup B)** Two (2) doses are required. Please indicate which brand received.  
   ( ) Bexsero - 2 dose series (1-2 months apart)  
   ( ) Trumenba - 2 dose series (6 months apart)  
   (M/D/Y M/D/Y M/D/Y)

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

<table>
<thead>
<tr>
<th>COVID-19</th>
<th>Hepatitis A</th>
<th>HPV (Human Papillomavirus Vaccine)</th>
<th>Influenza</th>
<th>Polio</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) Moderna ( ) Pfizer ( ) Johnson &amp; Johnson ( )</td>
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</tbody>
</table>

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]