The enclosed health forms **MUST** be completed and uploaded to the Student Health Portal no later than July 12th. Failure to comply will prevent students from obtaining a residence hall key upon arrival.

Please keep a copy of these completed forms for your records.

During the summer months, inquiries regarding the Health Forms are received weekday mornings after 9:00 a.m. at 610-758-3870.
Dear Entering Student:

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

Enclosed are your immunization and physical examination forms which must be completed and uploaded to your Student Health Portal by **July 12th** for Fall Admission or **January 12th** 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 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 (Td) 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)**
   - **At least 1 dose** prior to enrollment at Lehigh is required. If non-compliant; the student will not be able to obtain their residence hall room key. **Completion** of series within manufacturer guidelines is required for future registration.

*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 student 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  
Director, HWC  

Karen Sicinski, BSN  
Director of Nursing, HWC
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.

1. **Hepatitis B** A three (3) dose series is required. A blood test report indicating immunity is acceptable.

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.

3. **Tdap (Tetanus/Diphtheria/Pertussis) Vaccine within 10 years.**

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.

IMMUNIZATIONS AFTER AGE 16

5. **Meningitis (Serogroups A,C,Y, W135)** at least one (1) dose after age 16. *MenQuadfi, Menactra, Menevo or Menomune*

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)

Alternative Meningitis (Serogroups A, B, C, W, and Y) [ ] **PENBRAYA**

Second dose of **Trumenba** required after 6 months.

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>
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<td></td>
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<td></td>
</tr>
</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]
LEHIGH UNIVERSITY

PHYSICAL EXAMINATION 2024/2025

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 __________________________

Last Name __________________________

First Name __________________________

Middle Name __________________________

D.O.B. _______/_______/_______

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/____

<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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</tbody>
</table>

General Appearance

Head, Eyes, Ears, Nose, Throat

Lymph Nodes

Cardiovascular/Pulses

Respiratory/Lungs

Gastrointestinal

Musculoskeletal

Neurologic

Skin

# of Concussions __________________________

REQUIRED FOR VARSITY ATHLETIC PARTICIPATION:

**NCAA requires confirmation of sickle cell trait status for all 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]