



LAFAYETTE

Bailey Health Center

New Student & Transfer Students

Please Print this Packet

Complete Essential Medical Forms for
Class of 2024

LAFAYETTE COLLEGE

June 2020

Welcome Lafayette Students and Parents of the Class of 2024. The Bailey Health Center is committed to providing students with quality health care during their time at the College. Our services include primary care, treatment of acute medical problems and injuries, sports medicine, travel medicine, women's health services, and psychiatric care.

As a condition of enrollment at Lafayette, the Bailey Health Center must ensure that students meet certain health requirements. ***The College requires students to be immunized against several serious contagious diseases and to have a tuberculosis-screening questionnaire completed. The Health Center will ONLY accept this documentation on the forms the Bailey Health Center has posted on the Student Health Portal, signed by your physician. Students of the Class of 2024 will be unable to receive a room key on move in day unless these forms are completed.*** In addition to above forms, a Physical Examination is also required. It is critical that you allow sufficient time to see your healthcare provider, so please make an appointment as soon as possible.

The College also requires all students to have adequate health insurance while attending Lafayette. We ask that you carefully consider your health insurance options. The Lafayette College Student Health Plan (SHIP) is serviced by [University Health Plans](#) and is underwritten by Aetna Student Health. The cost of the SHIP for the coming year is \$1874. As a precondition for enrollment, the College requires that you submit proof of health insurance coverage. Please closely evaluate your coverage so that you can make informed decisions regarding your health insurance needs while at Lafayette.

We suggest you download and print [The Essential Medical Forms](#) and carefully review what is required as a condition of enrollment at Lafayette. The Health Center utilizes an electronic health record where all forms can be accessed on the [Patient Portal](#). To access the site you must enter your Lafayette username and password, which is the same one you would use to access your email.

We look forward to welcoming everyone to campus soon.

Be Well.

Sincerely,

Jeffrey Goldstein, MD

Director of Health Services

Emergency Notification Form

- Complete Online and submit by August 1 2020
- <https://Lafayette.medicatconnect.com>

Health History Form

- Complete Online and submit by August 1, 2020
- <https://Lafayette.medicatconnect.com>

Physical Form

- Print form, have your medical provider complete ALL sections and sign.
- <http://healthcenter.lafayette.edu/health-forms>
- Sign onto to the Patient Portal using the same credentials as your Lafayette email and upload completed form to your personal medical record.
- [Patient Portal](#)
- Physical exam MUST be completed on the form provided and submitted by August 1. 2020. There will be a \$50.00 surcharge for any physicals submitted in another format.

Immunization Record

- Print Immunization Record and provide to your medical provider to complete and sign. Please be sure your provider reviews ALL the required vaccines.
- <http://healthcenter.lafayette.edu/health-forms>
- Sign onto to the Patient Portal using the same credentials as your Lafayette email and upload completed form to your personal medical record.
- [Patient Portal](#)
- Immunizations MUST be recorded on the form provided and submitted by August 1, 2020. There will be a \$50.00 surcharge for any records submitted in another format.

Insurance Information

- Sign onto to the [Patient Portal](#) using the same credentials as your Lafayette email and complete the following two steps.
- First go to FORMS and complete the Insurance Form to enroll or to waive the option by providing proof of comparable insurance coverage. **If you DO NOT waive the option you will automatically be billed the \$1874 for the coverage.**
- Secondly, select the INSURANCE tab from the menu at the top of the page. Complete the form by entering the information on your insurance card and then uploading a copy of the front and back of your insurance card. If you are choosing the Lafayette College Student Health Plan (SHIP) please select that as your insurance company.
- BOTH requirements MUST be completed by July 15, 2020.

Tuberculosis Screening

- Print Form and complete.
- Sign onto to the Patient Portal using the same credentials as your Lafayette email and upload completed form to your personal medical record.
- [Patient Portal](#)
- A PPD Skin Test is only required if you answer “Yes” to any of the questions, if you plan to volunteer while at Lafayette, or if you are taking a class that requires it.

LAFAYETTE COLLEGE

PHYSICAL EXAMINATION

DATE: _____

NAME: LAST _____ FIRST _____ M.I. _____

- Vital signs: BP ___/___ Pulse _____ Height (inches) _____ Weight (pounds) _____
- Vision: (glasses) Yes ___ No ___ (Contact) Yes ___ No ___ (Uncorrected) Rt 20/___ Left 20/___
(Corrected) Rt 20/___ Left 20/___
- Urinalysis: (Specific Gravity) _____ (Sugar) _____ (Protein) _____ (other) _____
- * Sickle Cell Screening: Sickle cell disease: Yes ___ No ___ Sickle Cell Trait: Yes ___ No ___
**Mandated by the NCAA for student athletes*
- Are there abnormalities in any of the following systems? Describe fully abnormal findings.

	NORMAL	ABNORMAL
a. Head, Eyes, Ears, Nose & Throat		
b. Heart		
c. Lungs		
d. Vascular		
e. Musculoskeletal		
f. Metabolic/Endocrine		
g. Neurologic/Psychiatric		
h. Skin		
j. Genitourinary		

- ASSESSMENT: Please summarize all significant findings and elaborate on other items or recommendations that may be of importance in the care of this student. Thank you.

- RECOMMENDATIONS: (Cleared to participate in sports) Unlimited ___ Limited ___ (Explain) _____

PHYSICIAN'S NAME _____ SIGNATURE _____ DATE _____

ADDRESS (or office stamp) _____ PHONE (____) _____

Please return this form to the student so that all Health related forms can be returned together on or before **JULY 15th to:

**STUDENT HEALTH SERVICES
LAFAYETTE COLLEGE
607 HIGH STREET
EASTON, PA 18042-1768**



Bailey Health Center

IMMUNIZATION RECORD

Last Name, First Name: _____ L#: _____

Date of Birth: ____/____/____ Date of Entry: ____/____/____ Cell: (____) ____-____
M D Y M Y

THIS FORM MUST BE COMPLETED & SIGNED BY YOUR HEALTH CARE PROVIDER. ONCE COMPLETE FORMS CAN BE UPLOADED ONTO YOUR CHART USING THE UPLOAD OPTION ON THE STUDENT HEALTH PORTAL.

Pennsylvania State Law requires that all students residing in college owned housing be vaccinated against meningitis.

1. **Meningococcal Tetravalent (MCV4)** *Required* at least one dose **AFTER** the 16th birthday.

Dose #1 ____/____/____ Dose #2 (after the age of 16) ____/____/____

2. **Meningococcal Group B (Bexsero or Trumenba)** *Required*, several recent outbreaks of serogroup B meningitis on college campuses in this region highlight the importance of vaccinating for this deadly strain of meningitis.

This strain of meningitis is not covered by the traditional meningitis vaccine.

Trumenba Dose #1 ____/____/____ Dose#2 ____/____/____

Bexsero Dose #1 ____/____/____ Dose#2 ____/____/____

Many health care providers do not have the meningococcal group B vaccine. Trumenba will be available at the Bailey Health Center.

M.M.R. (Measles, Mumps, Rubella)

Required

1. Dose 1 given at age 12 months or later.....#1 ____/____/____
M D Y
2. Dose 2 given at least 28 days after first dose #2 ____/____/____
M D Y

Strongly Recommended

A third dose of MMR is strongly recommended because of several recent outbreaks of mumps on college campuses. Students previously vaccinated with 2 doses of MMR during childhood were not protected during these outbreaks. The Advisory Committee on Immunization Practices (ACIP) reviewed evidence and determined the third dose to be safe and effective.

3. Dose 3.....#3 ____/____/____
M D Y

POLIO

Required

Dose #1 ____/____/____ Dose#2 ____/____/____ Dose#3 ____/____/____ Dose#4 ____/____/____
M D Y M D Y M D Y M D Y

TETANUS-DIPHTHERIA-PERTUSSIS

Required

Primary series with booster with Tdap in the last ten years.

Tdap is recommended to protect against pertussis..... ____/____/____
M D Y

HEPATITIS B

Required

Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age or positive hepatitis B surface antibody meets the requirement.

1. Immunization (hepatitis B) Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
M D Y M D Y M D Y

OR

2. Immunization (Combined hepatitis A and B vaccine)

Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
M D Y M D Y M D Y

OR

3. Hepatitis B surface antibody Date ___/___/___ Result: Reactive ___ Non-reactive ___

VARICELLA (Chicken Pox)

Required

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or TWO doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in the U.S. before 1980 Yes ___ No ___

OR

2. Varicella antibody ___/___/___ Result: Reactive ___ Non-reactive ___

OR

3. Immunization

a. Dose #1 M / D / Y

b. Dose #2 given at least 12 weeks after first dose ages 1-12 years..... M / D / Y
and at least 4 weeks after first dose if age 13 years or older.

OTHER IMMUNIZATIONS:

HUMAN PAPILLOMAVIRUS 9-Valent VACCINE (Gardasil-9)

(Three doses of vaccine for college students 11-26 years of age at 0, 2, and 6 month intervals.)

Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___

HEPATITIS A

Dose #1 ___/___/___ Dose #2 ___/___/___

Typhoid ___/___/___

Yellow Fever ___/___/___

HEALTH CARE PROVIDER (must be signed by health care provider)

Name _____ Address: _____

I have discussed the risks/benefits of receiving the required immunizations with my provider. I will meet with the Director of Health Services and will sign a waiver for these immunizations before receiving a room key.

Student Signature: _____

LAFAYETTE COLLEGE

Student Health Insurance

Dear Students and Parents:

Lafayette College requires all students to have adequate health insurance. As you prepare for the 2020-2021 academic year, we ask you to carefully consider your health insurance options. The Student Health Insurance Plan (SHIP) is serviced by University Health Plans and is underwritten by Aetna Student Health. The cost of the SHIP for the coming academic year is \$1,874. As a precondition for enrollment, the College requires that you submit proof of health insurance coverage. The deadline for submitting insurance information to the College is July 15th. When students check in for the fall semester we will use the insurance information provided for COVID-19 testing and screening.

Please take a moment now and access your [Patient Portal](#), using your Network ID and password, select Insurance Form and complete to indicate your intention to waive the Student Health Plan or provide proof of a domestic health insurance policy. Then proceed to the Insurance tab and enter your policy information, and scan the front and back of your insurance card. Students must be enrolled in a domestic health insurance policy that provides adequate coverage in the Easton area. Pennsylvania Medicaid is the only exception to a domestic policy. Students will be enrolled and billed for the Lafayette SHIP unless they submit proof of insurance on the patient portal. Unlike past years, there is no requirement to waive SHIP on the University Health Plans website. To learn more about the Aetna Student Health Policy, access www.universityhealthplans.com

Please closely evaluate your coverage so that you can make informed decisions regarding your health insurance needs while at Lafayette.

We look forward to welcoming everyone back to campus soon.
Be well.

Sincerely,

Jeffrey Goldstein, MD
Director of Health services

TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY

Tuberculosis screening is required of all students entering Lafayette College, based upon guidelines of the American College Health Association and the U.S. Centers for disease Control. For more information, see www.acha.org or www.dcd.gov/tb

(Students) Last name _____ First _____ M _____ DOB _____

Section 1

Screening Questionnaire

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? YES NO
2. Were you born in one of the countries listed below that have a high incidence of active TB disease? YES NO

(If yes, please CIRCLE the country, below)

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, Colombia, Comoros, Congo, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran (Islamic Republic of), Iraq, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Tajikistan, Thailand, Timor-Leste, Togo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe

3. Have you had frequent or prolonged visits to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) YES NO
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? YES NO
5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? YES NO
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? YES NO

International Students; Section 2 will be completed at the Bailey Health Center upon arrival to campus.

*If the answer is YES to any of the above questions in section 1, Lafayette College requires that you have Tuberculin Skin Testing prior to the start of the semester. Proceed to section 2.

*If the answer to all of the above questions in section 1 is NO, no further testing or further action is required.

Section 2: Testing must be completed by a healthcare professional within the 12 months preceding the first day of classes. If TST is positive, a chest x-ray is REQUIRED.

Tuberculin Skin Test Date placed ___/___/___ Date read: ___/___/___ Results: ___# of mm induration

Date of Chest X-Ray (for positive TST): ___/___/___ (Must attach radiology report)

Provider Name (print): _____ Title: _____ Phone #: _____

Provider Signature: _____

Address/Official Stamp Here: