

**LAFAYETTE**  
**BAILEY HEALTH CENTER**

**New Students & Transfer  
Students**

Please Print this Packet

Complete Essential Medical Forms for  
Class of 2027

# LAFAYETTE COLLEGE

June 2023

Welcome Lafayette Students and Parents of the Class of 2027. 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, students are to be immunized against several serious contagious diseases and a tuberculosis-screening questionnaire must be 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. Records in any other format will result in a surcharge of \$50 to the student account. Students of the Class of 2027 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 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 Highmark. The cost of the SHIP for the coming year is \$2,584. 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 July 15, 2023
- <https://Lafayette.medicatconnect.com>

### Health History Form

- Complete Online and submit by July 15, 2023
- <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 July 15, 2023. **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 July 15, 2023. **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 steps.
- Select FORMS. Select Insurance Forms. Select that the student will either (1) enroll in School Health Insurance Plan(SHIP) or (2) waive the option of SHIP by providing proof of comparable insurance coverage. **If you DO NOT submit private insurance information and upload copies of your insurance card you will automatically be billed the \$2,584 for the SHIP coverage.**
- MUST be completed by July 15, 2023.

### 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](#)

# LAFAYETTE COLLEGE

## PHYSICAL EXAMINATION

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_ DOB \_\_\_\_\_

- Vital signs: BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Height (inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_
- Vision: (glasses/contacts) Yes \_\_\_ No \_\_\_ Rt 20/\_\_\_\_ Left 20/\_\_\_\_ Both 20/\_\_\_\_
- \*Sickle Cell Screening is REQUIRED for ALL NCAA Division I Athletes**  
Sickle Cell Disease: Yes \_\_\_ No \_\_\_ Sickle Cell Trait: Yes \_\_\_ No \_\_\_
- 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 provide any history pertinent to the care of the student. Attach any supportive documentation if necessary.

\_\_\_\_\_

- RECOMMENDATIONS: (Cleared to participate in sports) Unlimited \_\_\_ Limited \_\_\_ (explain further)

\_\_\_\_\_

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 15<sup>th</sup>** 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.**

### 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

1. Immunization (hepatitis B) Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_ OR
2. Immunization (Combined hepatitis A and B vaccine)  
Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_ OR
3. Hepatitis B surface antibody Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Reactive \_\_\_\_ Non-reactive \_\_\_\_

### MENINGOCOCCAL B (Bexsero or Trumenba)

#### **Required**

This strain of meningitis is not covered by the traditional meningitis vaccine. Given as Bexsero **OR** Trumenba.

Trumenba Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ OR  
Two doses given 6 months apart

Bexsero Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Two doses given 30 days apart

### MENINGOCOCCAL TETRAVALENT (MCV4)

#### **Required**

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 (must be received after the age of 16) \_\_\_\_/\_\_\_\_/\_\_\_\_

### MMR (Measles, Mumps, Rubella)

#### **Required**

Two doses required at least 28 days apart

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

### POLIO

#### **Required**

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #4 \_\_\_\_/\_\_\_\_/\_\_\_\_

### TETANUS-DIPHTHERIA-PERTUSSIS

#### **Required**

Primary series with booster with Tdap in the last ten years. Date of last Tdap \_\_\_\_/\_\_\_\_/\_\_\_\_

**VARICELLA (Chicken Pox)**

**Required**

History of chicken pox, a positive varicella antibody, **OR** TWO doses of vaccine

1. History of Disease Yes \_\_\_\_\_ No \_\_\_\_\_ **OR**

2. Varicella antibody \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Reactive \_\_\_\_ Non-reactive \_\_\_\_ **OR**

3. Immunization

Two doses given at least 12 weeks after first dose if age 1-12 years and at least 4 weeks after first dose if age 13 years or older

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

**COVID-19 VACCINE**

**Highly Recommended**

	Pfizer	Moderna	J&J	Other
Dose #1				
Dose #2				

**COVID BOOSTER**

**Highly Recommended**

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Brand: Pfizer Moderna Other\_\_\_\_\_ (Circle one)

Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Brand: Pfizer Moderna Other\_\_\_\_\_ (Circle one)

**HEPATITIS A**

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

**HUMAN PAPILLOMAVIRUS VACCINE (Gardasil-9)**

Two doses separated by 6 months for ages 9-14 **OR** three doses given at 0, 2 and 6 month intervals for ages 15 and up

Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_

**TYPHOID** \_\_\_\_/\_\_\_\_/\_\_\_\_

**YELLOW FEVER** \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Name (print) \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*I am requesting a waiver for required immunizations for medical / religious reasons. I will complete and submit the waiver request form directly through the student portal.*

Student Signature: \_\_\_\_\_ Date \_\_\_\_\_

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](http://www.acha.org) or [www.dcd.gov/tb](http://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

#### \*DOMESTIC STUDENTS\*

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

If the answer is **YES** to any of the above questions in section 1,

**Lafayette College requires that you have Tuberculin Skin Test (TST) or TB Gold Test prior to the start of the semester.**

Proceed to section 2.

#### \*INTERNATIONAL STUDENTS\*

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

### Section 2: TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY

Testing must be completed within 12 months preceding the first day of classes. If TST or TB Gold is positive, a chest x-ray is **REQUIRED**.

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

Tb Gold results: Date tested \_\_\_/\_\_\_/\_\_\_ Negative \_\_\_ Positive \_\_\_

Date of Chest X-Ray (for positive TST/TB Gold): \_\_\_/\_\_\_/\_\_\_ (Must attach radiology report)

Provider Name (print): \_\_\_\_\_ Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

**PROVIDER SIGNATURE:** \_\_\_\_\_

Address/Official Stamp Here:

# LAFAYETTE COLLEGE

## Student Health Insurance

June 2023

Dear Students and Parents:

Lafayette College requires all students to have adequate health insurance. As you prepare for the 2023-2024 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 Highmark. The cost of the SHIP for the coming academic year is \$2,584. As a precondition for enrollment, the College requires that you submit proof of private health insurance coverage if not accepting the SHIP. The deadline for submitting insurance information to the College is July 15th.

***ALL students are required to complete the insurance form annually regardless of changes from year to year.*** Please take a moment now and follow these steps to complete the form.

- ✓ Access your [Patient Portal](#) using your Network ID and password.
- ✓ Click “Forms”
- ✓ Click “Insurance Form”
- ✓ Enter the required demographic information
- ✓ Select student is (1) to be enrolled in the School Health Insurance Plan OR (2) covered under private health insurance plan verified to be equivalent to SHIP. If selecting private insurance, provide detailed information about the health insurance policy.
- ✓ Click “Upload” to upload a copy of the front and back of your insurance card.

Please note, 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.
- ***Out of State Medicaid IS NOT acceptable coverage.***
- ***International Students must purchase a domestic policy or choose SHIP.***
- To learn more about the Highmark Student Health Insurance Policy, access [University Health Plans](#)

Dental and Vision Coverage are supplemental options for all Lafayette students regardless of enrollment into the Student Health Insurance Plan. Access the University Health Plans webpage for enrollment costs and benefits.

As stated above, students will be automatically enrolled and billed \$2,584 for the Lafayette SHIP, unless they select private insurance and submit proof of insurance on the patient portal by July 15<sup>th</sup>.

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

Sincerely,

Jeffrey Goldstein, MD

Director of Health Services