HEALTH REQUIREMENTS
Athletic Training Program

**Acceptable documentation includes copies of childhood immunization records, immunization records/print-outs from a provider, and/or lab reports.

In accordance with the University of the Pacific’s Admission Policies (pg. 315 of the 2014 – 2015 general catalog), and acceptance into the Athletic Training (AT) Program students must complete and return a health form, medical history, physical exam, and immunization records to the Pacific Health Services located in the Cowell Wellness Center. The purpose of this form is only to provide evidence that those documents are in your health file. The information in your health file will not be released by the Pacific Health Services staff without your consent. Please take this form to Pacific Health Services to be completed by an appropriate provider. This form must be completed prior to admission into the Clinical Education Program in Athletic Training.

---- PLEASE ATTACH THIS FORM TO YOUR IMMUNIZATION RECORDS ----

Name _____________________________ Student ID # ___________________ Birth date ____________

REQUIRED:

☐ Health History and Physical Examination
  o Date Completed _______________________
    ▪ Complete the summer before starting the clinical education program.
    ▪ Must be completed between May 15th and July 15th, annually.
    ▪ Form is found at:
      ▪ http://www.pacific.edu/healthservices
    ▪ May be done at Pacific Health Services, in Cowell Wellness Center.
      ▪ If the student health fee has been paid
        o NOTE: there may be additional fees charged

☐ Hepatitis B Titer
  o Date Completed _______________________
    ▪ Hepatitis B Titer is a surface antibody showing immunity.
    ▪ Must have even if you have 3 vaccines.
    ▪ Must be completed by July 15th

☐ MMR (Measles, Mumps, Rubella)
  o Date Completed _______________________/_____________________
    ▪ Two documented vaccines or titers showing immunity.
    ▪ Must be completed by July 15th

☐ Tdap Vaccine (Tetanus, Diphtheria, Acellular Pertussis)
  o Date Completed _______________________
    ▪ One documented vaccine in the last 10 years
    ▪ Must be completed by July 15th
☐ Varicella (Chickenpox) Titer or verification of exposure or vaccines
  - Date Completed __________________________/________________________
    ▪ Two documented vaccines or titer showing immunity.
    ▪ Must be completed by July 15th.

☐ Tuberculosis Screening (see Tuberculosis Screening Information sheet located in the Health Center)
  - Date Completed __________________________/________________________
    ▪ 2-step PPD screening: MUST be completed between May 15th and July 15th before the start of your junior clinical year.
      ▪ NOTE: The 2-step assessment does not expire for a year. Yet it just does not meet one of our clinical affiliation’s requirements. So you may need an additional 1-step PPD screening completed during your academic year at your cost. The reason for this is if the student is observing a surgery at Dameron Hospital (Surgery Center) he or she may need to receive a single PPD screening within 60 day of the clinical observation. The AT Program Clinical Educational Coordinator will coordinate the timing of the single PPD assessment as needed.
  - Date Completed __________________________
    ▪ Annual 1-step PPD screening: Should be completed between May 15th and July 15th before the start of your senior clinical year.
  - If there is a history of a positive TB screening, the student MUST have Chest X-ray within 3 months of starting school.

☐ Meningitis Vaccine
  - Date Completed __________________________
    ▪ Recommended if living in Residence Halls and not updated in last 5 years or a signed disclosure statement.

☐ Influenza Vaccine
  - Dates Completed __________________________/________________________
    ▪ Must submit documentation of an annual influenza vaccine or vaccine declination if obtained off-campus or have it performed by Pacific Health Services at a Flu immunization clinic or in the clinic.
    ▪ To be offered at Pacific Health Services clinic in the beginning of September.

Comments:________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Pacific Health Services Practitioner ___________________________ Signature _______________ Date ____________
AT Program - Clinical Education Coordinator ___________________________ Signature _______________ Date ____________
AT Program – Director ___________________________ Signature _______________ Date ____________

If you have any questions on this form please contact the AT Program Director at (209) 946-2282 or AT Program Clinical Education Coordinator at (209) 946-3182.
Influenza Vaccine Form

Name _______________________________ Student ID# ____________________________
Program ____________________________ Birth Date ________ / ________ / _________

☐ I had the 2014-2015 Flu Vaccine at: ________________________________ Date ______________

(Provide verification)

You are strongly encouraged to provide documentation of Influenza vaccine:
☐ Injection
☐ Nasal spray

Student Signature _______________________________ Date ______________

☐ I DO NOT WANT THE FLU VACCINE

I acknowledge that I am aware of the following facts:
• Influenza is a serious respiratory disease that kills; on average, 36,000 Americans die every year from influenza-related causes.
• Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
• Some people with influenza have no symptoms, increasing the risk of transmission to others.
• Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In California, influenza usually begins circulating in early January and continues through February or March.
• I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
• I have declined to receive the influenza vaccine for the 2015-2016 seasons. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

☐ *Because I choose not to be vaccinated for influenza, I have been advised that in order to protect the safety of my patients and myself during this flu season I am strongly encouraged and may be required to wear a mask when delivering patient care.

☐ *Because I choose not to be vaccinated for influenza I will assume all additional responsibilities and costs associated with the placement and completion of my experiential coursework. Additional costs could include the cost associated with being fitted for special masks and the actual masks.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

I decline vaccination for the following reason(s) – Please check all that apply:
☐ A. I believe I will get influenza if I get the vaccine.
☐ B. I do not like needles.
☐ C. My philosophical or religious beliefs prohibit vaccination.
☐ D. I have an allergy or medical contraindication to receiving the vaccine.
☐ E. I do not wish to say why I decline.
☐ F. Other reason – please tell us.

Student Signature _______________________________ Date ______________

Pacific Health Services Practitioner Signature Date ________________________________

AT Program - Clinical Education Coordinator Signature Date ________________________________

AT Program – Director Signature Date ________________________________