STUDENT
HEALTH SERVICES
UNIVERSITY OF THE PACIFIC

Dear Pacific Student,

Please read this packet carefully. It contains critical information for your success as a student.

It is our pleasure to welcome you to the University of the Pacific and to introduce you to Student Health Services. We provide student-centered health care to Pacific students, promote optimal wellness, and assist students to achieve their academic goals through quality health services. Some highlights about our services:

- All students who pay the Cowell Wellness fee may access all services regardless of their insurance coverage.
- Student Health Services offers:
    - Healthcare with referral service as needed
    - Physicals
    - Immunization review and administration
    - TB screening and testing
    - Preventive screenings
    - Women's care
    - Contraceptive services
    - STI testing and treatment
    - Online medical portal
    - Dietitian Services
    - After Hours Nurse Advice line (209-946-2315 option 4)

Additionally, Student Health Services monitors student health and communicable disease clearance and compliance.

Prior to starting at the University of the Pacific, there are several health clearance requirements that need to be completed.

A checklist with requirement deadlines and several required documents are enclosed in this packet for your convenience.

Thank you and we look forward to keeping you healthy and well during your academic journey.

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NEW STUDENT CHECK- LIST

COMPLETE ITEMS ONLINE PRIOR TO ARRIVAL

HEALTH SERVICE: www.pacific.edu/immunizationcompliance

Visit the Medical Portal link (www.go.pacific.edu/myhealth) under the Medical Clearance Tab to complete forms.

- ☐ Complete Health History Questionnaire
- ☐ Enter immunization dates **and** submit immunization/lab documentation
- ☐ Acknowledgement of Patient Lab Service Policy
- ☐ Acknowledgement of No Show Cancellation Policy & Fee Schedule
- ☐ Acknowledgement of Receipt of Notice of Privacy Practices
- ☐ Acknowledgement of Telehealth Consent

STUDENT HEALTH INSURANCE: www.pacific.edu/insuranceoffice

- ☐ Students are automatically enrolled in the Student Health Insurance Plan (SHIP)
  **automatic enrollment criteria varies, please review enrollment criteria @www.pacific.edu/insuranceoffice*
- ☐ Eligible students are automatically charged the insurance premium each term.
- ☐ If you would like to waive out of SHIP you must apply for a Health Insurance waiver prior to your first day at the University EACH ACADEMIC YEAR. To submit a waiver, please visit www.pacific.edu/insuranceoffice.

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REQUIREMENTS FOR HEALTH PROFESSION MAJORS

(Audiology, Athletic Training, Clinical Nutrition, Dentistry, Dental Hygiene, Music Therapy, Occupational Therapy, Pharmacy, Physical Therapy, Physician Assistant, Speech Language Pathology, and Social Work)

☐ **Physical Examination**

- Physical Examination to be completed no greater than 3 months prior to matriculation
  Physician Assistant Program: Annual Requirement

☐ **Hepatitis B Surface Antibody Titer** (Blood Test)

- Hepatitis B Surface Antibody titer results proving immunity (quantitative preferred; qualitative accepted).
- *For negative titer results*, submit documentation of previous Hepatitis B vaccination(s) **and** demonstration series has been restarted.
  Pharmacy/Physician Assistant Programs: Quantitative Hepatitis B Surface Antibody titer proving immunity as a numerical value (within 5 years).
  Occupational Therapy Program: series of 3 doses only; Quantitative Hepatitis B Surface Antibody titer due prior to clinical experiences

☐ **MMR** (Measles, Mumps, Rubella)

- Two documented doses *OR* Antibody titer proving immunity (quantitative preferred; qualitative accepted)
  Pharmacy/Physician Assistant Programs: MMR antibody titer proving immunity (within 5 years)

☐ **Varicella Vaccine** (Chickenpox): Documentation of disease is not acceptable

- Two documented doses *OR* antibody titer proving immunity (quantitative preferred; qualitative accepted)
  Pharmacy/Physician Assistant Programs: Varicella Antibody titer test showing immunity (within 5 years)

☐ **Tdap Vaccine** (Tetanus, Diphtheria, Acellular Pertussis) **Td Vaccine** (Tetanus, and diphtheria toxoids)

- One documented dose of Tdap (after age 10)
- Td booster every 10 years
  Physician Assistant Program: One documented dose of Tdap within 3 years of matriculation

☐ **Influenza Vaccine (Annual Requirement due by November 1st)**

- Documentation of Influenza for current season
- Influenza Declination Form – check with program coordinators if clinical site mandates vaccine and/or mask requirements. Submit declination form to medical portal **and** to program coordinators.
  Dentistry Program: clinics TBA in October

☐ **Tuberculosis Testing Initial Requirement**

- No history of positive PPD test or disease:
  - 2 step PPD screening or QFGT blood test within 3 months of matriculation
- History of positive PPD or disease:
  - Chest X-ray within 6 months of matriculation.
  - Documentation of previous BCG vaccination, latent TB or active TB treatment
- **Annual Requirement:**
  - No history of positive PPD or disease: 1 step PPD
    Pharmacy Program: 2 step PPD/QFGT
    Physical Therapy Program: 2 Step PPD or QFGT must to be completed between August 15th-September 30th
  - History of positive PPD: complete Tuberculosis review form *(additional requirements if medically indicated)*

☐ **Meningococcal Conjugate Vaccine**

- One documented dose administered at 16 years of age for students under 22 years of age at entrance.

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HISTORY AND PHYSICAL (Required for Health Profession Majors)

This document consists of a two paged History and Physical. It is to be completed by a Physician, Nurse Practitioner or Physician's Assistant, signed and dated on page 2.

STUDENT'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ GENDER: _____ STUDENT ID #:_____

SCHOOL ADDRESS: _____

PHONE NUMBER: _____ MAJOR: _____GRAD YEAR: _____

PAST MEDICAL HISTORY:

Significant past health problems, major illnesses/injuries, surgeries, hospitalizations:
_____

Childhood Diseases: _____

Medications (Prescribed, Vitamins, Supplements, OTC) within the last 3 months:
_____

Drug allergies & reactions: _____

FAMILY HISTORY:

Parents: _____

Siblings: _____

SOCIAL HISTORY:

Employment: _____

Exercise program: _____

4. Dietary Patterns: _____

SUBSTANCE USE:

Alcohol: _____ Tobacco: _____ Recreational Drugs: _____

REVIEW OF SYSTEMS:

General: _____ Ears: _____

Skin: _____ Nose: _____

Head: _____ Throat: _____

Eyes: _____ Mouth:_____

NAME: _____ **ID #:** _____

ROS:
Breasts: _____ **Ob/Gyn:** _____

Resp: _____ **MS:** _____

CV: _____ **Neuro/Psych:** _____

GI: _____ **Heme/Lymph:** _____

GU: _____ **Endo:** _____

Other: _____

PHYSICAL EXAMINATION:

Ht _____ **Wt** _____ **BMI** _____**BP** _____ **Pulse** _____ **Resp** _____ **Temp** _____

Visual Acuity Right 20/_____ **Left 20/**_____ **Both 20/**_____ **uncorrected corrected**

Sexually Active: Yes_____ **No**_____ **Number of Children:**____

(Write "N/A" if item does not apply to student)

GENERAL/Mental Status: _____

SKIN: _____ **LUNGS:** _____

HEAD: _____ **CV:** _____

EYES: _____ **ABD:** _____

EARS: _____ **EXT:** _____

NOSE: _____ **NEURO:** _____

THROAT: _____ **GU MALE:** _____

NECK: _____ **LAST PELVIC RESULT:** _____ **DATE:**_____

BREASTS: _____

ASSESSMENT AND PLAN:

Health recommendations: _____

Please review the student's immunization status, provide the necessary vaccines and/or titers to complete entrance requirements. Please provide documentation of immunizations.

Please review the student's TB status, administer the appropriate TB screening and provide appropriate documentation of TB clearance to complete entrance requirements

_____ _____ _____
Signature of Provider/Printed Name **License #** **Date**

_____ _____
Address of Provider (Stamp preferred) **Phone/Fax Numbers**

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Student Name: _____
Student ID#: _____
Phone#: _____

Tuberculosis Screening Questionnaire

Have you:

1. Ever had a positive TB test? ☐ Yes ☐ No
   a. If yes, have a chest x-ray performed within 6 months of matriculation.
   b. If no, skip to question #4.
2. Ever had a BCG vaccine? *attach documentation* ☐ Yes ☐ No
3. Ever been treated with INH? *attach documentation* ☐ Yes ☐ No
   a. If yes, dates given: _____
4. Had any vaccinations administered in the past 4 weeks? ☐ Yes ☐ No
5. Had any chronic or recurrent symptoms *lasting 3 weeks or longer*:
   a. Productive cough or spit up blood? ☐ Yes ☐ No
   b. Unexplained or recurrent fever, chills or night sweats? ☐ Yes ☐ No
   c. Unexplained fatigue? ☐ Yes ☐ No
   d. Chest pain? ☐ Yes ☐ No
   e. Unexpected weight loss or loss of appetite? ☐ Yes ☐ No
6. Had a health practitioner tell you that your immune system is suppressed? ☐ Yes ☐ No
7. Traveled overseas for more than 2 weeks in the last 12 months? ☐ Yes ☐ No
8. Been exposed to a family, volunteer and/or employee of high-risk congregate settings to TB in the last 12 month? (Ex: correctional facilities, long-term care facilities, homeless shelter) ☐ Yes ☐ No

Explain *Yes* answers _____
_____

☐ ***I declare that my answers/statements are correctly recorded, complete and true to the best of my knowledge.***

Student Signature _____ **Date:** _____

PPD Skin Tests: (No history of positive PPD result/disease)

	Admin Date	Site	Admin Name/title	Read Date	mm Induration	Neg/Pos	Read Name/title
PPD #1		LFA/RFA					
PPD #2		LFA/RFA					

Note: *PPD#2 must be administered 1-3 weeks apart from first placement. If each test is not read within 48-72 hours, then test/s must be repeated.*

Chest X-ray: (History of positive PPD skin test) *attach radiology report:*

Date: _____/ _____/ _____ ☐ Positive ☐ Negative

Quantiferon Gold/TSpot: *attach laboratory result*

Note: Result not acceptable for students in Pharmacy and Physician Assistant Programs.

Date: _____/_____/_____ ☐ Positive ☐ Negative

Medical Facility Stamp:

Sumbit documentation: Medical Portal (go.pacific.edu/myhealth)>Downloadable Forms Tab>Additional Immunization Records Category