STUDENT
HEALTH SERVICES
UNIVERSITY OF THE PACIFIC

Dear Pacific Student and Parents/Guardians:

Please read this packet carefully. It contains critical information for your success as a student and requirements for entry/start date.

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
    - Tuberculosis(TB) screening and testing
    - Preventive screenings
    - Pap Smear Exams
    - 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 SERVICES: www.pacific.edu/immunizationcompliance

Visit the Medical Portal link (https://healthservices.pacific.edu) under the "Medical Clearance" tab to complete forms.

- Complete Health History Questionnaire
- Enter immunization dates **and** submit immunization/lab documentation/exemption form(attached) if applicable -Exemptions: Any vaccine, including Covid-19 Vaccine, must be accompanied by a medical exemption form (attached) filled out by a provider.
- 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.

STUDENT
HEALTH SERVICES

UNIVERSITY OF THE PACIFIC

REQUIREMENTS FOR HEALTH PROFESSION MAJORS

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

****Please note these are University requirements and each program might have their own requirements aside from these.****

Physical Examination

- Physical Examination to be completed **NO GREATER than 3 months prior to matriculation.** Please ensure the ENTIRE form is completed, to prevent any delays.

Hepatitis B Surface Antibody Titer (Blood Test)

- Hepatitis B Surface Antibody, **Quantitative** titer results proving immunity
- *For negative titer results*, submit documentation of all Hepatitis B vaccination(s) **and** that booster has been received or series has been restarted.

MMR (Measles, Mumps, Rubella)

- Two documented doses *OR* **Quantitative** Antibody titer proving immunity
- **Pharmacy/Physician Assistant Program/Nursing:** Quantitative Antibody titer proving immunity (within 5 years) **in addition** to vaccines

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

- Two documented doses *OR* **Quantitative** Antibody titer proving immunity
- **Pharmacy/Physician Assistant Programs/Nursing:** Quantitative Antibody titer test showing immunity (within 5 years) **in addition** to vaccines

Tdap Vaccine (Tetanus, Diphtheria, Acellular Pertussis):

- One documented dose of Tdap (after age 7)
- Tdap booster every 10 years

Influenza Vaccine (Annual Requirement due by October 15th)

- Documentation of Influenza for current season must be dated after July 15th to be current
- Influenza Declination Form – check with program coordinators if clinical site mandates vaccine and/or mask requirements. Submit declination form **and** medical exemption form to medical portal **and** to program coordinators.

Tuberculosis Testing Initial Requirement

- No history of positive PPD test or disease:
  - 2 PPD skin tests or Quantiferon blood test **WITHIN** 3 months prior to matriculation
- History of positive PPD or disease:
  - Quantiferon Blood Test
  - Documentation of previous BCG vaccination, latent TB or active TB treatment
- **Annual Requirement for ALL HEALTH PROGRAMS**
  - No history of positive PPD skin test or disease, ALL health programs: 1 PPD skin test w/in the year of initial TB clearance, Quantiferon blood test
    Pharmacy Program: 2 PPD skin tests, Quantiferon Blood Test or Chest Xray
  - History of positive PPD skin test or Latent TB: complete Tuberculosis review form *(additional requirements if medically indicated*) in addition to Quantiferon Blood Test

Meningococcal Conjugate Vaccine

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

Covid-19 Vaccine

- Documentation of up-to-date vaccination depending on eligibility & CDC guidelines. (1 dose of an updated Covid-19 Vaccine (Moderna, Novavax or Pfizer)

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HISTORY AND PHYSICAL (Required for ALL 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. *ALL MUST BE COMPLETED FOR CLEARANCE. (Write "N/A" if item does not apply to student)*

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: ***all Vitals & Visual Acuity sections must be completed for clearance***

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

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

Sexually Active: Yes_____ **No**_____

ASSESSMENT: (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:** _____ **O DEFERRED**

NECK: _____ **LAST PAP SMEAR:** _____ **RESULTS:** NORMAL ABNORMAL

BREASTS: _____ **O DEFERRED**

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 **License #** **Date**

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

STUDENT HEALTH SERVICES
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Student Name: _____
Student ID#: _____
Date of Birth: _____
Phone#: _____
Program: _____

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 setting 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***

Date: _____/_____/_____ ☐ Positive ☐ Negative

Medical Facility Stamp:

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

Revised 03/06/2024

University Immunization Medical Exemption Form

UNIVERSITY OF THE PACIFIC

CERTIFICATE OF MEDICAL EXEMPTION

Immunization Requirements

Student's Name _____ ID# _____ Birth Date _____

A. **Check box for which an exemption is being claimed:** *One vaccine per medical exemption certificate*

☐ **INFLUENZA** ☐ **VARICELLA** ☐ **MMR** ☐ **TDAP** ☐ **MENINGOCOCCAL CONJUGATE**

OTHER: _____

In the event of a disease outbreak you may not be allowed on campus. The period of exclusion may be for a few days up to several months and may extend to two incubation periods after the last case depending upon the disease and the number of cases.

B. To be completed by Medical Provider:

I, _____ [Name of licensed MD, DO, PA, NP] certify that the above-named student has:

☐ A medical condition that contraindicates his/her vaccination with _____ vaccine

Please check the appropriate box and list below either:

a) ☐ The applicable CDC contraindication to this vaccine*, or

b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or

c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

*REQUIRED: **Description of contraindication meeting criteria a, b, or c above:**

_____

_____

_____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: _____

Titers for immunity to this disease: (attach laboratory results)

☐ Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

(Provider stamp here)

_____
Physician Signature

_____
Physician License Number

_____
Date

_____
Parent Signature (*required if student is under 18 years)*

Please submit to Student Health Services Medical Portal for review.

Revised 03/06/2024

Request for Medical Exemption for COVID-19 (SARS-CoV-2) Vaccination- Stockton, San Francisco and Sacramento Campuses

Name_____ ID#_____ Date of Birth_____
Pacific email address: _____

UNIVERSITY OF THE PACIFIC requires all students enrolled in Health Science Programs to be **fully vaccinated** against COVID-19 and that they **stay up to date** with any required boosters to participate on campus in classes. A person is **fully vaccinated** two weeks after receiving all recommended doses in their primary series of COVID-19 vaccine. **Staying up to date** means a person has received doses, as recommended by the CDC. Use this form to request an accommodation or exemption from this requirement for medical reasons.

Information about COVID-19

COVID-19 is a respiratory illness caused by a newly discovered coronavirus that typically causes mild to moderate illness, like the common cold, but can lead to dangerous complications. COVID-19 is a very contagious virus and new variants are continuing to emerge. The COVID-19 vaccines available in the United States have been carefully evaluated in clinical trials and have been authorized for emergency use and/or fully approved by the U.S. Food and Drug Administration because they make it substantially less likely that an individual will contract COVID-19 and become seriously ill. COVID-19 vaccines have been found to be safe and effective. For more information, please consult: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html, or your health care provider.

When you are vaccinated against COVID-19, you don't just protect yourself—you protect your friends, family members, coworkers and everyone in the community—especially those who are at increased risk for severe illness from COVID-19 or are medically unable to receive the vaccines themselves. More studies are ongoing to determine the vaccines' ability to keep people from spreading the virus that causes COVID-19 and how long the vaccines continue to protect from serious illness.

If you qualify for a medical exemption from Pacific's vaccination requirement, please indicate your reason below:

□ Medical (Please refer to the Medical Exemption Certification on Page 2—this must be completed by a licensed medical provider to complete your vaccination exemption)

Acknowledgment and Signature

I have read the above information about COVID-19 vaccination. I understand that by declining this vaccine I continue to be at risk of acquiring COVID-19, which is a serious disease. I may be excluded from certain events or activities depending on health guidance or other requirements. I will follow university standards which may require wearing additional personal protective equipment while on campus, and I may be subject to continuing COVID-19 testing. **If clinical education or external fieldwork is part of my academic program, I understand that sites may restrict unvaccinated individuals and the university may not be able to find a suitable alternative. Without completing the clinical or fieldwork placements, I may be delayed or prevented from completion of my academic program or licensure requirements.**

I understand that the university may change its vaccination policy in the future and require additional measures for those who are not vaccinated. I agree that if at any future point while attending and/or working at Pacific I decide to receive the COVID-19 vaccine, I will provide proof of vaccination and then this exemption will be considered revoked.

I verify that I am 18 years of age or older, that I understand this Request for Exemption Form and have had the opportunity to ask questions about it.

Student or employee signature: _____ Campus: _____

Parent or Legal Guardian Signature*: _____ Date: _____
*Needed only if student is under 18 years of age

Name_____ ID#_____ Date of Birth_____

COVID-19 MEDICAL EXEMPTION CERTIFICATION

Instructions: Please complete this form to release information regarding your request for an accommodation exempting you from receiving the COVID-19 vaccine due to your health condition.

I have provided this certificate, signed and dated by my licensed health care provider, certifying that receiving the COVID-19 vaccine is contraindicated due to applicable CDC contraindications and/or my medical condition. I consent to allow University of the Pacific representatives to contact my health care professional(s) to obtain copies of medical records related to my condition, and to consult with the health care professional(s) regarding my condition, only as it relates to my ability to receive the above vaccine.

Signature: _____ Date: _____

Parent or Legal Guardian Signature*: _____
*Needed only if student is under 18 years of age

(TO BE COMPLETED BY A LICENCED MEDICAL PROVIDER):

I, _____ [Name of licensed MD, DO, PA, NP] certify that the above-named student/employee is under my medical care and has a medical condition that contraindicates their vaccination with the COVID-19 Vaccine at this time. This contraindication is based on (choose one):

☐ The applicable CDC contraindication(s) to this vaccine

☐ The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe

This contraindication is: □ Permanent or □ Temporary

Other recommended accommodations (if any): _____ Other

recommended accommodations related (if any): _____

_____

If temporary: the expiration date of the exemption for this vaccine is _____

Health Care Provider Signature: _____ Date: _____

License Number: _____

Health Care Provider Name and Contact Info: _____
[Name]

_____
[Address]

_____

Telephone: _____ Fax: _____