

Health Clearance

Doctor Of Pharmacy

Immunization, Health History, and Physical Examination Information

Remember to keep copies of all your health records for future use on experiential rotations.



120 N. Clovis Avenue,
Clovis CA. 93612

Phone: (559) 325-3600

Fax: (559) 473-1487

Email: admissions@chsu.org

www.chsu.org

Dear Student,

A complete Health History, Physical Examination, Tuberculosis Clearance, Serum Blood Titers, TDAP vaccines and Proof of Immunization are required **prior to registration** at California Health Sciences University (CHSU).

Once you have completed all of the above requirements, including the attached forms, forward all of the documents to the Office of Admissions by June 30. You WILL NOT be allowed to complete the registration process without providing the required documents.

The following is a list of all health related documents that are **mandatory and required prior to June 30**:

1. Student Information (**FORM 1**) *Student signature required.
2. Health History (**FORM 2**) *Student AND Health Care Provider signatures required.
3. Physical Examination (**FORM 3**) *Health Care Provider signature required.
4. Tuberculosis Clearance (**FORM 4**) *Health Care Provider signature required.
 1. **PPD 2-Step - (Have PPD #1 completed. Wait 7-10 days from PPD #1 reading date, to have PPD #2 placed.)**
 2. **TB Screening (PPD skin tests and/or chest x-ray results) must be completed between June 1-June 25.**
 3. **Chest X-ray** – Only required for those with PPD (+) – Required Annually.
5. Authorization for Release of Communicable Disease Clearance Information to Clinical Rotation Sites (**FORM 5**) *Student signature required.
6. California State Required Meningitis Awareness Disclosure (**FORM 6**) *Student signature required.

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7. Proof of Immunization for the following vaccinations (copies preferred):

1. **TDAP** (tetanus/diphtheria/pertussis). **TDAP** is considered current if administered within 10 years.
 - *TD or DTAP will not be accepted.*
 - *2 MMR (Measles, Mumps, Rubella). 2 documented doses of when the live vaccine was given.*

8. Laboratory Results (serum blood titers) for the communicable diseases below.

1. **Titers considered current if completed within 5 years.**
2. **Laboratory Results must include reference ranges and be on laboratory letterhead.**
3. **If immunity is not present according to serum blood titer, student must obtain vaccination and serum blood titer retest.**
 - Hepatitis B Surface Antibody Titer- Qualitative (HBsAb)
 - Measles (Rubeola) Antibody Titer- Qualitative (Measles AB, IgG, EIA) (if there is no documentation of 2 doses)
 - Mumps Antibody Titer- Qualitative (Mumps AB, IgG) (if there is no documentation of 2 doses)
 - Rubella Antibody Titer- Qualitative (MMR Ab, IgG) (if there is no documentation of 2 doses)
 - Varicella Antibody Titer- Qualitative (Varicella AB, IgG)

All information will be handled in compliance with HIPAA regulations related to protected health information.

Revised 6/3/15

Health Clearance Check List

Take with you to all Health Care Provider Visits

**Upon completing the Health Clearance requirements,
submit the information as one entire packet to the Office of Admissions by June 30.**

You **WILL NOT** be allowed to complete the registration process without providing these requirements by June 30:

COMPLETED
ON

- _____ Student Information (**FORM 1**) *Student signature required.
- _____ Health History (**FORM 2**) *Student AND Health Care Provider signatures required.
- _____ Physical Examination (**FORM 3**) *Health Care Provider signature required.
- _____ Tuberculosis Clearance (**FORM 4**) *Health Care Provider signature required.
- PPD 2-Step - (Have PPD #1 completed. Wait 7-10 days from PPD #1 reading date, to have PPD #2 placed.)**
Two-step testing is useful for the initial skin testing of adults who are going to be retested periodically, such as health care workers. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection.
 - TB Screening (PPD skin tests and/or chest x-ray results) completed between June 1-June 25.**
 - Chest X-ray** – Only required for those with PPD (+) – Required Annually.
- _____ Authorization for Release of Communicable Disease Clearance Information to Clinical Rotation Sites (**FORM 5**) *Student signature required.
- _____ California State Required Meningitis Awareness Disclosure (**FORM 6**) *Student signature required.
- _____ Proof of Immunization for the following vaccinations (copies preferred):
- TDAP** (tetanus/diphtheria/pertussis). **TDAP** is considered current if administered within 10 years.
 - *TD or DTAP will not be accepted.*
 - MMR** (Measles, Mumps, Rubella). 2 documented doses of when the live vaccine was given.
- _____ Laboratory Results (serum blood titers) for the communicable diseases below.
- Hepatitis B Surface Antibody Titer - Qualitative (HBsAb)
 - Varicella Antibody Titer - Qualitative (Varicella AB, IgG)
 - Measles (Rubeola) Antibody Titer - Qualitative (Measles AB, IgG, EIA) (if there is no documentation of 2 doses)
 - MumpsAntibody Titer - Qualitative (MumpsAB, IgG) (if there is no documentation of 2 doses) Rubella Antibody Titer - Qualitative (MMR Ab, IgG (if there is no documentation of 2 doses)
- _____ **Titers completed within 5 years.**
- _____ **Laboratory Results include reference ranges and are on laboratory letterhead.**

If immunity is not present according to serum blood titer, student must obtain vaccination and serum blood titer retest.

Submit this signed, completed checklist along with your entire, completed Health Clearance (forms and documentation) packet to the Office of Admissions by June 30 via U.S. Mail or Hand Delivery Only to:

Student Name

Student Signature

Date

CHSU College of Pharmacy, Office of Admissions
120 N. Clovis Avenue, Clovis, CA 93612

Phone: (559) 325-3600 or Email: admissions@chsu.org

Please call Office of Admissions at (559) 325-3600
if accepted to program after June 1.

Form 1: Student Information

*This section to be completed and signed by the student.
Please use ink and print clearly.*

Name: _____ Program/Yr.: _____ Student ID: _____

Gender: M F Date of Birth: ____ / ____ / ____ Telephone Number: _____

Marital Status: Single Married Separated Divorced Widow

Current Address: _____

Street Address

City

State

Zip Code

Personal Email: _____

CHSU Email: _____@chsu.org

Health Insurance Carrier: _____

Person to notify in case of an emergency/accident:

Name: _____ Relationship: _____

Last

First

Middle

Address: _____

Street Address

City

State

Zip Code

Telephone: _____ Mobile: _____

Email: _____

Student Signature: _____

Date: _____

Form 2:

Health History

This section to be completed and signed by the student,
then reviewed and signed by the student's Health Care Provider.
Please use ink and print clearly

Name: _____ Program/Yr.: _____ Student ID: _____

Gender: M F Date of Birth: ____ / ____ / ____ Telephone Number: _____

Allergies (drugs/food): _____

Medications currently taking: _____

Place a check mark if you currently or have ever had any of the following:

HEAD

- Major dental problems
- Dizziness or Fainting
- Encephalitis

EYES/EARS/NOSE/THROAT

- Eye trouble
- Wear glasses
- Wear contact lenses
- Allergies
- Ear trouble
- Hearing problem
- Frequent nosebleeds
- Hay fever
- Frequent sore throat

ENDOCRINE

- Hypothyroid
- Hyperthyroid
- Diabetes mellitus

**CHEST/HEART/LUNGS/
VASCULAR**

- Breast disease or masses
- Chest Pain/Pressure
- Heart Disease/Murmur
- High Blood Pressure
- Rapid or irregular pulse
- Varicose veins
- Asthma
- Chronic cough
- Emphysema
- Lung Disease
- Night Sweats
- Pleurisy
- Wheezing
- Shortness of Breath
- Coughing up Blood

GASTROINTESTINAL

- Abdominal Pain
- Recent changes in appetite
- Recent changes of bowel habits
- Recent constipation
- Frequent diarrhea
- Digestive disorder
- Difficulty swallowing
- Recurrent emesis (vomiting)
- Gastric or duodenal ulcer
- Hemorrhoids/Rectal fissures
- Other ano-rectal disorders
- Hernia
- Intestinal worms
- Jaundice
- Black bowel movements
- Vomiting blood
- Intestinal inflammation
- Gall bladder disease
- Hepatitis

GENITOUINARY

- Urine contains: Blood/
Albumin/Sugar
- Kidney disease
- Bladder disease
- Painful urination
- Frequent urination
- Genital disorder
- Frequent urinary tract infection
- Other

SURGICAL HISTORY

- Appendectomy
- Gall Bladder
- Pelvic Surgery
- Cesarean Section
- Tonsillectomy
- Other

**MUSCULOSKELETAL/
NEUROLOGICAL**

- Arthritis
- Chronic muscle pain
- Spine problem, e.g., disc
or vertebrae
- Swollen of painful joints/
extremities
- Bone infection
- Amputation
- Speech defect
- Rheumatic Fever
- Cluster headache
- Migraine headaches
- Paralysis, tremors,
muscle weakness
- Neuralgia or numbness

BLOOD DISORDER

- Anemia
- Rheumatic Fever
- Sickle Cell
- Lymphoma
- Other

MENTAL HEALTH

- Frequent Nightmares
- Trouble concentrating
- Cry often
- Feeling of Depression
- Tendency to worry
- Memory Loss
- Metal Health Disorder
- Feelings of Loneliness
- Considerable nervousness
- Difficulty Sleeping
- Considered Suicide
- Require use of Sleeping aids
- Other

**ADDITIONAL MEDICAL
HISTORY**

- Cancer
- Unusual fatigue
- Frequent Colds
- Serious illness
- Sexual Problems
- Skin disorder/infections
- Unexplained weight gain or loss
- Other

FEMALES ONLY

- Abnormal pap smear
- Ovarian cysts
- Pelvic inflammatory
disease (PID)
- Pregnancy: G P
- Painful menses (dysmenorrhea)
- Fibrocystic disease
- Other

SOCIAL HISTORY

- Smoke Tobacco
- Alcohol Use
- Recreational Drug Use
- Other

**CONDITIONS THAT MAY
NOT BE LISTED:**

Student Signature: _____

Date: _____

Reviewed by: _____

Date: _____

Health Care Provider's signature

Form 3:

Physical Examination

To be completed and signed by the student's health care provider.
This can be no more than 6 months old.

120 N. Clovis Ave, Clovis CA. 93612

Phone: (559) 325-3600

Fax: (559) 473-1487

Name: _____
Last First Middle

Date of Birth: ____ / ____ / ____

Gender: M F BP (sitting): ____ / ____ Pulse: _____ Respirations: _____

Ht: _____ Wt: _____ R: ____ /20 L: ____ /20 Corrected Uncorrected

| EXAMINATION | NORMAL (Please Check) | ABNORMAL (Please Check) | DESCRIPTION |
|--|--------------------------|----------------------------|-------------|
| GENERAL: Posture, Gait, Speech, Appearance | | | |
| HEAD: Hair, Symmetry, Tenderness | | | |
| EYES: Lids, Sclera, Conjunctiva, Muscles. | | | |
| EARS: Pinna, Canal, Drum, Hearing | | | |
| NOSE: Septum, Obstruction, Mucosa | | | |
| MOUTH/THROAT Breath, Lips, Teeth, Tongue, Pharynx. | | | |
| NECK: Thyroid, Motion, Trachea, Veins | | | |
| LYMPHATICS: Cervical, Supraclavicular, Axillary | | | |
| LYMPHATICS: Cervical, Supraclavicular, Axillary | | | |
| CARDIOVASCULAR: PMI, Rate, Rhythm, Sound, Murmur... | | | |
| ABDOMEN: Tenderness, Organs, Hernia, Masses.. | | | |
| MUSCULOSKELETAL: Back, Upper extremities, lower..... | | | |
| SKIN: Birthmarks, Rashes, Scars, Texture | | | |
| NEUROLOGIC DTR's, Biceps, Triceps, Patella, ETC | | | |
| MENTAL STATUS: ALOCx3, Affect, Judgment, ETC..... | | | |

Findings: _____

Please describe any significant emotional problems: _____

Are there any recommendations for continued medical care? Yes No

If yes, please explain: _____

Health Care Provider Name: _____ Phone Number: _____

Signature: _____ Date: _____

Address of Health Care Provider: _____

Form 4: Tuberculosis Clearance

To be completed and signed by the student's health care provider.
Please use ink and print clearly



120 N. Clovis Ave, Clovis CA. 93612

Phone: (559) 325-3600

Fax: (559) 473-1487

Annual TB Screening, Symptom Survey & PPD

Name: _____ Program/Yr.: _____

DOB: _____ Student ID: _____

Annual TB Screening & Symptom Survey

The recommendations for obtaining and interpreting a PPD are the same whether or not you have had a BCG vaccination.

1. Have you ever lived or recently traveled to another country? Yes No
 - a. If yes, when and where _____.
2. Have you ever had a positive PPD skin test? Yes No
 - a. If yes, date _____ and size in _____ mm induration.
 - b. Date of last chest x-ray _____.
3. Have you ever been told you have active tuberculosis? Yes No
4. Have you ever taken INH or any other anti TB medication? Yes No
 - a. If yes, name of medication(s) _____ and duration _____
medications were taken. _____ months.
5. Has a close member of your family ever been diagnosed or treated for tuberculosis? Yes No
6. Have you ever worked in a healthcare setting before? Yes No
7. During the past year have you had any symptoms below?

| | | | | | |
|------------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Unexplained weight loss? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Decrease in appetite? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Persistent cough? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood streaked sputum? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Night Sweats? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unexplained low grade fever? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Swelling of the lymph nodes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unusual tiredness or fatigue? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Student's Signature: _____ Date: _____

Reviewed By: _____ Date: _____

Provider's name

2 Step PPD

**Step
1
PPD**

| | | |
|-----------------------|----------------|---------------|
| Date Placed: | Date Read: | Manufacturer: |
| Time Placed: | Time Read: | Lot #: |
| RFA LFA | mm Induration: | Exp. Date: |
| Placed By: | Ready By: | |
| Comments: | | |
| Signature of Provider | | Date: |

_____ For healthcare workers, if Step 1 PPD is < 10 mm, place Step 2 PPD within 7-14 days. If Step 1 PPD is ≥ 10 mm, obtain CXR and consider further testing or possible treatment of latent TB infection (LTBI) per CDC recommendations.

**Step
2
PPD**

| | | |
|-----------------------|----------------|---------------|
| Date Placed: | Date Read: | Manufacturer: |
| Time Placed: | Time Read: | Lot #: |
| RFA LFA | mm Induration: | Exp. Date: |
| Placed By: | Ready By: | |
| Comments: | | |
| Signature of Provider | | Date: |

_____ For healthcare workers, if Step 2 PPD is < 10 mm, continue with annual PPD. If Step 2 PPD is ≥ 10 mm, obtain CXR, and consider further testing or possible treatment of latent LTBI per CDC recommendations.

Provider's Signature: _____ Date: _____

Address & Phone: _____

Form 5:

Authorization for Release of Communicable Disease Clearance Information to Clinical Rotation Sites

*This section to be completed, signed and dated by the student.
Please use ink and print clearly*



120 N. Clovis Ave, Clovis CA. 93612

Phone: (559) 325-3600

Fax: (559) 473-1487

College of Pharmacy, Class of: _____

I _____ born on _____, hereby authorize:

California Health Sciences University
College of Pharmacy
Office of Admissions
120 N. Clovis Avenue Clovis, CA 93612
(559) 325-3600

To release to the extent permitted by law, the following medical information that California Health Sciences University now has in its possession, or that it may create or receive from any third party in the future:

Initial next to the documents you are authorizing for release

_____ Immunization information (including titer results)

_____ Tuberculosis clearance

_____ History and Physical Exam report

Other: _____

to any of the clinical rotation site(s) of the University that I am or will be assigned to as a student of the University. I understand that this information must be provided, if requested, in order to prove to a clinical rotation site that I meet all communicable disease clearance requirements as required by the University. I also understand that if I do not allow this information to be provided by the various clinical rotation sites, a clinical rotation site can refuse to allow me to rotate through its facility. I am also acknowledging that if I cannot complete the clinical rotations required for my degree and/or licensure because of my refusal to authorize the release of my communicable disease clearance information to the clinical rotation sites, I agree to hold the University harmless to the extent permitted by the law. I also am aware that this Authorization will remain in effect for the duration of my time as a student at California Health Sciences University and will expire on the date of my graduation from the University.

Signature of Student

Printed Name of Student

By signing this Authorization on this _____ day of _____ 20 _____,
I agree with all the provisions stated in this Authorization for the release of the specified information.

Form 6: Meningitis Awareness Disclosure

This section to be completed, signed and dated by the student.

Please use ink and print clearly

California State Required Meningitis Awareness Disclosure Form

California law requires that universities make an increased effort to educate students about the risk of Meningococcal disease or "Meningitis." Although the incidence of Meningitis is relatively rare – about one case per 100,000 persons per year – studies done by the CDC and American College Health Association (ACHA) found that the cases of Meningococcal disease are three to four times higher among college freshman that live in the resident halls. The Meningococcal vaccine is effective against the four kinds of bacteria that cause about two-thirds of the Meningococcal disease in the United States.

What is Meningococcal Meningitis?

Meningococcal meningitis is a potentially fatal infection cause by the bacterium *Neisseria meningitides* that causes inflammation of the membranes surrounding the brain and spinal cord.

How is Meningitis Spread?

Meningitis is spread by direct contact with infected individuals. The bacterium is present in respiratory secretions and can be spread by coughing or sneezing. It is also spread by sharing eating utensils, water bottles, cigarettes, and kissing. Social factors such as smoking, excessive alcohol consumption, and bar patronage also increase the chance that a person will contract meningitis from an infected individual.

Is There a Vaccine for Meningitis?

There are two vaccines available that are 85% to 100% effective in preventing four kinds of bacteria that cause about 70% of disease in the U.S. Menomune, the Meningococcal polysaccharide vaccine (MPSV4) has been available since the 1970s. Menactra, the Meningococcal conjugate vaccine (MCV4) was licensed in 2005. Both vaccines work well and are safe with generally mild side effects such as redness and pain at the injection site, lasting up to two days. Immunity develops within 7-10 days after vaccination and lasts approximately 3-5 years. The newer Menactra vaccine is the preferred vaccine for people 11-55 years of age and is expected to give better, longer-lasting protection and should also be better at preventing the disease from spreading from person to person.

What are the Symptoms of Meningitis?

Cases of Meningitis peak in late winter and early spring, overlapping the flu season. Symptoms can easily be mistaken for the flu. These symptoms may include high fever, rash, vomiting, severe headache, neck stiffness, lethargy, nausea, and sensitivity to light. If a student has two or more of these symptoms at one time, they should seek health care immediately. Meningitis progresses rapidly and can lead to shock or death within hours of the first symptoms if left untreated.

If you have questions regarding the Meningitis vaccines, please contact your health care provider. More information can be found at the CDC website (www.cdc.gov) or the ACHA website (www.acha.org).

We will keep this confidential as part of your medical record in accordance with HIPAA. Please indicate your preference and acknowledgement of this information by signing below:

Mark one of the Boxes, then Sign Below

- I have received the meningococcal vaccine with 5 years. Date: ___/___/_____. Please provide proof of immunization.
(*Hib meningitis does NOT qualify*)
- I have read the provided information and do not want to receive either vaccine _____. (initial)

Student Signature

Student ID #

Student Name (Please Print Clearly)

Date

Please return to: California Health Sciences University, Office of Admissions, 120 N. Clovis Ave., Clovis, CA 93612