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.

CHSU
CALIFORNIA HEALTH SCIENCES UNIVERSITY

120 N. Clovis Avenue,
Clovis CA. 93612

Phone: (559) 325-3600

Fax: (559) 473-1487

Email: admissions@chsu.edu

www.chsu.edu

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 below requirements, including Forms 1-6, upload all of the documents to CORE (see included tip sheet) 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. TB Screening - to be completed by your health care provider
    2. PPD 2 Step - (PPD skin tests and/or chest x-ray results) must be completed between June 1-June 25.
        - 1 step PPD required annually
        - **Chest X-ray/Quantiferon-TB Gold** – Only required for those with PPD (+)

5. Authorization for Release of Communicable Disease Clearance Information to Clinical Rotation Sites **(FORM 5) *Student signature required, initials and date required.**

6. California State Required Meningitis Awareness Disclosure **(FORM 6) *Student signature along with date of vaccine or initials required.**

7. Proof of Immunization for the following vaccinations (copies required):
    1. *TDAP (tetanus/diphtheria/pertussis). TDAP is considered current if administered within 10 years. - TD or DTAP will NOT be accepted.*

    2. *MMR #1, #2 (Measles, Mumps, Rubella). Two documented doses and dates of when the live vaccine was given.*

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Doctor of Pharmacy

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.**

        - Hepatitis B Surface Antibody Titer- Qualitative (HBsAb)
        - Varicella Antibody Titer- Qualitative (Varicella AB, IgG)

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

        • Hepatitis B Surface Antibody Titer- Qualitative (HBsAb)
        • Varicella Antibody Titer- Qualitative (Varicella AB, IgG)
        • MMR (2 documented doses of the vaccine)

Steps for obtaining serum blood titers:

- **Hepatitis B** (3 doses of vaccine)
- **Varicella** (2 doses of the vaccine)

Received Vaccinations:

- Provide documentation of vaccinations
- Obtain serum blood titers
- If serum blood titers are negative, obtain booster dose of the vaccine
- Repeat serum blood titers (must be at least 6 weeks after last dose of vaccinations)
- If serum blood titers are negative for a second time, obtain a doctor's note stating no immunity

Did Not Receive Vaccinations:

- If no documentation of ever getting the vaccinations in the past, obtain vaccinations
- Obtain serum blood titers (must be at least 6 weeks after last dose of vaccination)
- If serum blood titers are negative, obtain booster dose of the vaccine
- Repeat serum blood titers (must be at least 6 weeks after last dose of vaccination)
- If serum blood titers are negative for a second time, obtain a doctor's note stating no immunity

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

Once you have completed all of the below requirements, including Forms 1-6, upload all of the documents to CORE (see included tip sheet) 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.**

- ☐ **TB Screening** - to be completed by your health care provider
- ☐ **PPD 2-Step - PPD skin tests and/or chest x-ray results) must be completed between June 1 - June 25.**
  - **PPD 1 Step** - Required annually
  - **Chest X-ray/Quantiferon-TB Gold** – Only required for those with PPD (+)

_____ Authorization for Release of Communicable Disease Clearance Information to Clinical Rotation Sites **(FORM 5) *Student signature required, initials and date required.**

_____ California State Required Meningitis Awareness Disclosure **(FORM 6) *Student signature along with date of vaccine or initials required**

_____ Proof of Immunization for the following vaccinations (copies required):

- ☐ **TDAP** (tetanus/diphtheria/pertussis). **TDAP** is considered current if administered within 10 years.
  - *TD or DTAP will not be accepted.*
- ☐ **MMR** (Measles, Mumps, Rubella). Two 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)

_____ **Titers completed within 5 years.**

_____ **Laboratory Results include reference ranges and are on laboratory letterhead.**

Upload this signed, completed checklist along with your completed Health Clearance Packet(forms and documentation) to CORE by June 30 :

_____
Student Name

_____ _____
Student Signature Date

Form 1:
Student Information

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

CHSU
CALIFORNIA
HEALTH SCIENCES
UNIVERSITY

120 N. Clovis Ave, Clovis, CA 93612
Phone: (559) 325-3600
Fax: (559) 473-1487

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

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

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Address: _____
Street Address

_____
City State Zip Code

Personal Email: _____

CHSU Email: _____@chsu.edu

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:** _____

Rev 10/25/17

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

CHSU
CALIFORNIA HEALTH SCIENCES UNIVERSITY
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Fax: (559) 473-1487

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

GENITOURINARY
- ☐ 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 rever
- ☐ 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

Rev 10/25/17

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.

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UNIVERSITY

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Phone: (559) 325-3600
Fax: (559) 473-1487

Name: _____ Date of Birth: _____ / _____ / _____
Last *First* *Middle*

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 Extremities			
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: _____

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Form 4:
Tuberculosis Clearance

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

CHSU
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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) _____
   b. 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 ☐	No ☐	Decrease in appetite?	Yes ☐	No ☐
Persistent cough?	Yes ☐	No ☐	Blood streaked sputum?	Yes ☐	No ☐
Night sweats?	Yes ☐	No ☐	Unexplained low grade fever?	Yes ☐	No ☐
Swelling of the lymph nodes?	Yes ☐	No ☐	Unusual tiredness or fatigue?	Yes ☐	No ☐

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 number: _____

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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

CHSU
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HEALTH SCIENCES
UNIVERSITY

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:

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

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HEALTH SCIENCES
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Phone: (559) 325-3600
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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 within 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

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