Samuel Merritt University
Student Health And Counseling
(SHAC)

Peralta Medical Office Building
3100 Telegraph Avenue, Suite 3105
Oakland, CA 94609

Telephone (510) 879-9288

Congratulations on your admission to Samuel Merritt University.
Welcome to the SHAC!
(Student Health and Counseling)

REQUIRED FORMS

All students are required to complete the ***Student Health Forms*** **as soon as you have been accepted to the program,** ***but no later than*** ***30 days before your program start date in order to avoid a registration hold.*** All required health information must be entered on the Student Health Portal (SHP) and supporting documents must be uploaded to the Student Health Portal (SHP) at https://studenthealth.samuelmerritt.edu/. Documents submitted by mail, email, fax, or hand-delivered will NOT be accepted and documents will not be returned.

Required vaccines are offered at Student Health and Counseling Center for a fee. Appointments are required and can be scheduled by calling the SHAC. Students consulting their own healthcare provider must have their provider fill out and sign the Immunization form (office stamp required).

Mandatory Student Health Insurance Enrollment Form must be completed online at https://app.hsac.com/smu All SMU students are required to have acceptable medical health insurance coverage in effect by their program's first day of orientation. For more information, please visit the insurance website.

SERVICES

We invite you to utilize our clinic for your health care needs during your academic tenure. We provide health care screenings, minor acute care, family planning, as well as counseling services. We understand that student life can be a difficult transitional period with increased pressure and stress, our counseling staff works to help students understand this period. All currently enrolled SMU students are eligible for up to 10 counseling appointments per calendar year.

Medical visits at SHAC are free of charge to currently enrolled students. Please call Student Health and Counseling Center at (510) 869-6629 for an appointment. Our fees schedule for the required vaccines is listed below (fees updated on 3/1/16.) Full payment is required at the time of service. **We only accept cash or check.**

PPD Skin Test	**No charge**	**Tdap Vaccine**	**$40**
Flu Vaccine	**No charge**	**Hepatitis B Vaccine**	**$65 per dose**
		MMR Vaccine	**$80 per dose**

For x-rays, laboratory tests such as TB Quantiferon, titers, Pap smear, or other diagnostic tests, we will refer you to the appropriate labs. You will be responsible for any lab charges incurred at the laboratory.

Save this cover letter for future reference, upload the required documents, and keep the completed health forms for your records. We look forward to meeting and working with you!

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Student Health Record Checklist

(All health records are due 30 days before your Official Program Start Date)

Below are the health records that must be submitted online upon acceptance to Samuel Merritt University. Immunization records (yellow card, physician's vaccine records, or SMU's immunization history) must be completed, signed, and dated by a MD, PA or NP. Blood titers submitted for Hep B, MMR, and Varicella must show positive immunity. If titers show negative immunity, the entire vaccine series (not just a booster) must be repeated. The first dose of the vaccine series must be completed before you begin clinical. Holds will not be lifted until the whole series is complete. ***This checklist is for your record only. You do not need to upload this page online.***

_ **Flu Vaccine:** Required every flu season

_ **Tdap (Tetanus, Diphtheria, Pertussis):** One Tdap vaccine within the past 10 years. *Td will not satisfy this requirement*

_ **Hepatitis B Vaccine:** 3 doses required. Dose 1 to Dose 2: minimum 4weeks apart; Dose 2 to dose 3: minimum 8 weeks apart AND at least 16 weeks after first dose **Or**
Positive Hepatitis B sAb Titer (surface antibody)

_ **MMR (measles, mumps, rubella) Vaccines:** 2 doses required (no age exception due to our health science institution.) Minimum 4 weeks apart between Dose 1 to Dose 2. **Or**
Positive Rubeola IgG Titer, positive Rubella IgG Titer, and positive Mumps IgG Titer

_ **Varicella Vaccination:** 2 doses required. Minimum 4 weeks apart between Dose 1 to Dose 2. **Or**
Positive Varicella Zoster IgG Titer

Tuberculosis Skin Test (TST) aka PPD: *(Must be done within **6 months** before your program start day)*

_ Negative 2-step PPD: 2-step as defined by CDC: 1st test placed and read within 48-72 hours. 2nd test placed at least 1 week after 1st placement, but no longer that 3weeks, and read within 48-72 hours.
Or

_ A negative Quantiferon TB Gold blood test (IGRA) *(Must be done within **6 months** before program start day)*
Or

Individual with a history of Positive TST (PPD):

_ A negative chest x-ray (within ***12 months*** before program start date; CXR report is required.) **And**

_ Completed Tuberculosis Screening Survey. Depending on date of conversion, evidence of latent tuberculosis treatment may be required.

_ **Student Health Insurance:** All students are required to have medical insurance coverage as of first day of program orientation. Apply for Waiver online if you already have insurance coverage

_ **Student Health Record, Consent to Release Record, and Health History Forms** (p.3-7 of this packet)

_ **There may be additional requirements from your academic program or clinical placements, including (but not limited to) vaccine titers, color vision testing, and physical exam. Please check with your Clinical Coordinator.**

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Student Health Record

<table>
<tr><td colspan="4">LAST NAME FIRST MIDDLE</td><td>GENDER</td><td colspan="5">DATE OF BIRTH (MM/DD/YYYY)</td></tr>
<tr><td colspan="4"></td><td></td><td colspan="5"></td></tr>
<tr><td colspan="5">LOCAL
Address:
City/State/Zip:
PERMANENT HOME ADDRESS (If different)
Address:
City/State/Zip:</td><td colspan="5">STUDENT CONTACT NUMBERS
Local Home Phone: ( )
Mobile Phone: ( )
Permanent Home Phone: ( )
E-mail Address:</td></tr>
<tr><td colspan="5">EMERGENCY CONTACT
Name:
Relationship:
Address:
City/State/Zip:</td><td colspan="5">EMERGENCY CONTACT NUMBERS
Home Phone:
Cell Phone:
Work Phone:</td></tr>
<tr><td colspan="5">CAMPUS LOCATION (check one)</td><td colspan="3">TERM ENTERING (check one)</td><td colspan="2">YEAR ENTERING</td></tr>
<tr><td colspan="5">Oakland SF Peninsula Sacramento Online</td><td>Fall</td><td>Spring</td><td>Summer</td><td colspan="2"></td></tr>
<tr><td colspan="10">ACADEMIC PROGRAM ENTERING (check one)</td></tr>
<tr><td>RN-BSN</td><td>BSN</td><td>ABSN</td><td>ELMSN, CM, FNP
FNP/DNP, DNP</td><td>T2P</td><td>CRNA</td><td>MPA</td><td>DPT</td><td>MOT</td><td>DPM</td></tr>
</table>

Consent for Treatment and Limited Release of Records

CONFIDENTIALITY: Unless you give permission, no confidential information (other than as indicated below) is provided to any other department of the University or to anyone or other organization outside the University. In addition, the information you provide on these forms is not seen by the Admission staff and does not impact consideration of your application for admission.

TREATMENT: I hereby authorize Student Health & Counseling Center / Summit Medical Center to provide such medical services as deemed necessary during the period of time that I am a student at Samuel Merritt University.

LIMITS OF RELEASE OF RECORDS: I give permission for Samuel Merritt University Student Health & Counseling Center to make available information regarding dates of my completion of physical exams, immunization requirements and PPD testing results to my clinical instructors and to the clinical institutions where I will train.

The information provided above and on the attached forms is complete and true to the best of my knowledge.

Student Signature: ____ Date ______________________________

Parent or Guardian Signature:_______________________________ Date ______________________________
(for students under 18 years old)

PRINT Student Name: ____________________________________ **Date of Birth:** ___________________________

Student Name ____ **Date of Birth** ___________________

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Consent to Release Records

I, (print name clearly)_________________________________, hereby give my consent to Samuel Merritt University to release any and all of the following information to clinical agencies and training sites that are part of my clinical experiences, for my education at Samuel Merritt University.

I, (print name clearly)__________________________________, hereby give my consent to Student Health at Samuel Merritt University to release my immunization records including but not limited to immunization dates and results, lab results, and my TB Skin Test results to my educational department to share with clinical agencies and training sites that are part of my clinical experiences for my education at Samuel Merritt University.

- Name, local address, e-mail address, phone number
- Birth date
- Criminal Background check
- Immunization records and/or titres with dates and results
- TB Skin Test results
- Lab results
- Health Compliance Records
- Verification of health insurance (if applicable)
- Last 4-digits of social security number
- CPR
- Blood borne pathogen training dates (Health)
- HIPPAA training dates
- Health Care licensure (if applicable)

I understand that this information is used solely for the necessary operations at the clinical agencies and training sites, including but not limited to credentialing, computer access, medication systems, and building access during my clinical rotation.

____

Signature of Student   Date

Student Name ______________________________ **Date of Birth** ______________

Personal Health History p.1

CONFIDENTIAL MEDICAL HISTORY: On the following pages, if you need to list additional items or explanations, utilize any extra space within the section or continue on the back side of the appropriate page (making note of this within that section).
* The information you provide here will be kept within the SHAC office. If you would like to request academic accommodations for any health condition disclosed here, please contact Disability Resource Center at drc@samuelmerritt.edu

Check all that apply, if you have or have had any of the following.

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-immune disease
- ☐ Back injury or surgery
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/alcohol abuse
- ☐ Eating disorder
- ☐ Emotional abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Frequent urine infection
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Learning disability
- ☐ Lupus erythematosis
- ☐ Migraine headache
- ☐ Neurological disorders
- ☐ Physical abuse
- ☐ Sexual relations against your will
- ☐ Sickle cell disease
- ☐ Skin problems
- ☐ Stomach or bowel ulcers
- ☐ Tuberculosis
- ☐ Vision problems
- ☐ Weight loss or gain

☐ **NONE of the above**

Surgeries and Hospitalizations

List dates, types of surgery (if applicable), and reasons for hospitalization.

Date	Surgery or Hospitalization

Describe any other significant health conditions you may have, including physical limitations: ______________

Provide details of any conditions that you have indicated above.

Condition & Current Status	How Controlled	Dates of Onset & When Resolved

☐ **No Surgery or Hospitalization**

Student Name ____________________ Date of Birth ____________

Personal Health History: Allergies p.2

List allergies to any medications and other substances, and describe the type of reaction to each.

Allergy	Reaction

☐ **NO Known Drug/Allergies**

Medications

List all medications you are currently taking. Include birth control pills, vitamins, medicinal herbs, and non-prescription medications.

Medication	Dose & Frequency	Reason for taking this medicine

☐ **NONE**

Personal Habits

Briefly describe your current dietary and exercise habits.

Check all the apply:

	How much?		How much?
☐ Smoke Cigarettes		☐ Recreational Drugs	
☐ Smoke cigars		☐ Drink coffee	
☐ Chew tobacco		☐ Drink tea	
		☐ Drink alcohol	

Diet: ____________________

Exercise: ____________________

Student Name ______________________________ **Date of Birth** ____________________

Personal Health History: Family p.3

Family Health History: Please check all that apply

Illness	Mother	Father	MGM*	MGF*	PGM*	PGF*	Siblings	Children
Alcoholism								
Allergies								
Asthma								
Cancer, breast								
Cancer, other **								
Chronic lung disease								
Diabetes								
Heart disease								
High blood pressure								
Osteoporosis								
Stroke								
Thyroid disease								

* *MGM (maternal grandmother), MGF (maternal grandfather), PGM (paternal grandmother), PGF (paternal grandfather)*

** For other cancer, please list type: ______________________________

☐ **NONE of the above**

Social History

List all current members of your household. Include spouse or significant other, children, other family members, and any other people who live with you.

Name	Relationship	Age	Current Health Status

Sexual History (Optional)

For Female Only:

Date of last pap smear:______________________________

Do you think you could be pregnant now? __Yes __No

Any pregnancies? __Yes __No How many?_________

Both Male and Female:

Have you ever had sexual contact? __Yes __No

If yes, with: ____Men ____Women ____Both

Number of lifetime partners: __________

Condom use: ___Always ___Sometimes ___Never

Student Name: ______________________________ **Date of Birth:** ____________

Tuberculosis Screening Survey

(Only complete if you have a history of POSITIVE PPD)

NOTE: Do not upload this form if you have always had a negative PPD

Complete this page only if you have had a positive PPD skin test in the past.
You will also need to fill out and **upload a *new survey*** on the Student Health Portal ***every 12 months*** while a student at SMU.

1. Date of last **positive PPD** (MM/DD/YYYY): ____________ Test Result: ________ **mm induration**

2. Where were you born? ______________________________
   If you were born outside of the United States, how long have you been here? ____________

3. Have you had vaccinations with Bacillus of Calmette & Guerin (BCG)? ☐ Yes ☐ No ☐ Don't know
   If "Yes": When? ____________ Where? ____________

4. Have you ever traveled, worked, and/or lived outside the United States? ☐ Yes ☐ No
   If "Yes": Dates ____________ Places ____________

5. Are you aware of any exposure to people with possible active TB (i.e., high-risk populations, such as refugees, immigrants, homeless individuals, persons with chronic cough, or household members with TB infection)?
   ☐ Yes ☐ No If "Yes," describe nature of possible exposure: ______________________________

Dates	Places	Length of Contact

6. During the past 12 months, have you noticed any of the following?

	Yes	No		Yes	No
Productive cough (3 weeks)			Swollen glands, usually in neck		
Persistent weight loss without dieting			Recurrent kidney or bladder infections		
Persistent low grade fever			Coughing up blood		
Night sweats			Shortness of breath		
Loss of appetite			Chest pain		

Please provide details of any "Yes" answers above: ______________________________

Student Signature: ✍ ______________________________ Date Completed: ____________

Patient name ______________________________ DOB ________________

Immunization History (Signed by MD, PA, DO, NP Only)

You must either: **1) Enter and upload documentation to Student Health Portal**: your childhood immunization records, vaccine (yellow) card, hospital or physician's records, lab reports **OR**

2) Have your healthcare provider (***physician, physician assistant, or nurse practitioner***) verify dates and results from your records, fill out and sign this form and **upload to Student Health Portal**

Any blood work done for titers/antibodies must show positive immunity; otherwise, entire vaccine series must be repeated/completed *(not just a booster).* **All dates must be in MM/DD/YYYY format**

Health Requirement	Dates (MM/DD/YYYY)	Result / Immunity		Notes
FLU VACCINE (Seasonal)	Date: ________			*Required every flu season*
Tdap (Td will not be accepted) (Tetanus, Diphtheria, Petussis)	Date: ________			*Within last 10 years from program start date*
HEPATITIS B Vaccines *(3 doses)*	**1.** ________ **2.** ________ **3.** ________			
or Hepatitis B sAb Titer	Date: ________	☐Pos.	☐Neg.	☐ Equivocal *If negative or equivocal, need to repeat 3 doses of vaccines.*
MMR—MEASLES, MUMPS, RUBELLA Vaccines *(1 or 2 doses, see note)*	1. ________ 2. ________			*(no age exception due to health science institution)*
or Rubeola IgG Titer	Date: ________	☐Pos.	☐Neg.	☐Equivocal
Rubella IgG Titer	Date: ________	☐Pos.	☐Neg.	☐Equivocal *If any are negative or equivocal,*
Mumps IgG Titer	Date: ________	☐Pos.	☐Neg.	☐Equivocal *need to repeat 2 doses of vaccine*
VARICELLA Vaccines *(2 doses)*	1. ________ 2. ________			*History of Varicella does not fulfill this requirement. If you had the chickenpox, have your titer checked*
or Varicella Zoster IgG Titer	Dates: ________	☐Pos.	☐Neg.	☐Equivocal *If negative or equivocal, need 2 doses of vaccines.*
PPD—TB SKIN TEST **Negative 2-step PPD***	1st step Date Placed ________ Read ________	☐Pos.	☐Neg.	Induration (mm): ________
				PPDs must be done within 6 months before program start date
**A two-step PPD is two separate PPD placements; within 1-3 weeks apart.*	2nd step Date Placed ________ Read ________	☐Pos.	☐Neg.	Induration (mm): ________
OR **Quantiferon-TB Gold**	Date: ________	☐Pos.	☐Neg.	***Quantiferon TB Gold must be done within 6 months before Program start date***
OR **Positive PPD History** Chest X-Ray	Date: ________	Result ________		***X-ray within 12 mos. before Program start date*** ***Student must fill out Tuberculosis Screening Survey***

I have verified all dates and results, and certify them to be correct to the best of my knowledge.

Date signed ______________________

Clinician Signature ______________________

Print Name and Title ______________________

Address ______________________

City/ State/ Zip ______________________

Telephone ______________________

Office Stamp Required