March 13, 2015

Dear Doctor:

The patient you are examining has been accepted to the University of the Pacific Arthur A. Dugoni School of Dentistry. Students must provide all information on the attached forms in order to matriculate on time.

FORMS:

- Health Requirements Form
- History and Physical Form
- Tuberculosis (TB) Screening Information

Please complete and return the History and Physical form and documentation of patient’s immunization records, with the Health Requirements form attached, to the Pacific Health Services on the Stockton campus located at 3601 Pacific Avenue, Stockton, CA 95211, in an envelope marked “confidential”.

If you have questions, please contact Beth McManis, Director of Health Services at 209.946.2315 (option 1).

Sincerely,

Kathy Candito
Associate Dean for Student Services
Dear Dental Student:

It is our pleasure to welcome you to the University of the Pacific and to introduce you to the Pacific Health Services at San Francisco. We provide student-centered primary care to Pacific students and promote optimal wellness and assist students to achieve their academic goals through quality health services. We respect the diversity of our students and are sensitive to their religious preferences and personal beliefs and practices. We encourage you to become involved in promoting healthy attitudes and lifestyles for yourself.

Health Services are delivered by Nurse Practitioners, who collaborate with a physician from Dignity Medical Group. Clinical hours are available three days a week at the San Francisco clinic when school is in session. Students may call Pacific Health Services on the main campus during business hours if they have questions when the San Francisco clinic is closed. A Dietitian also is available to consult with students regarding their nutritional needs. Students are eligible to use the Counseling Services on the Stockton campus.

In an effort to reduce our carbon footprint on the environment, the majority of our forms have been moved on-line. They can all be found at http://www.pacific.edu/Campus-Life/Student-Services/Health-Services/Entrance-Health-Requirements.html. You will need to have your health care provider complete the Medical Examination form. You will need to mail this form and documentation of your immunization records to Pacific Health Services at the Stockton campus. The rest of the forms can be completed on-line via MyHealth@Pacific (https://healthservices.pacific.edu/login_directory.aspx). A list of the forms and their deadline dates is included in the on-line check off list which is attached. Our electronic medical record system meets The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules.

An attached check-list is provided for your convenience. Please take time to review it and complete the required tasks by the stated deadlines. Thank you and we look forward to providing health services to you. If you have any questions, please call 209-946-2315 (option 1).

Patrick Day
Vice President
Division of Student Life

Kathy Candito
Director of Admissions
Assoc. Dean for Student Services

Beth McManis
Ph.D., NP, CNM
Director of Health Services
Division of Student Life
HEALTH REQUIREMENTS
Dental Students

(Acceptable documentation includes copies of childhood immunization records, immunization records/print-outs from a provider, and/or lab reports.)

Please attach this form to your immunization records.

Name _____________________  Student ID # ________________Birthdate ___________________  DDS ☐  IDS ☐

Required  AEGD ☐  Endo ☐  Oral Surg. ☐  Ortho ☐

Health History and Physical Examination
- Complete and return by June 12, 2015. Physical needs to be done on or after March 1, 2015.
- Form is found at http://www.pacific.edu/Campus-Life/Student-Services/Health-Services/Entrance-Health-Requirements.html

Hepatitis B
- Hep B Surface Antibody showing immunity (Must have even if you have had 3 vaccines –Please see explanation sheet)
- Three documented vaccines (Titer will suffice if documentation is not available. Send in documentation of the three vaccines in ADDITION to the HBsAb titer.)
- If Hep B Surface Antibody is negative, administer one (1) Hepatitis B vaccine if documentation of three vaccines is available.

MMR (Measles, Mumps, Rubella)
- Two documented vaccines or titer showing immunity

Tdap Vaccine (Tetanus, Diphtheria, Acellular Pertussis)
- One documented vaccine in the last 10 years (Td will not be accepted)

Varicella Vaccine (Chickenpox)
- Two documented vaccines or titer showing immunity (History of disease is not acceptable.)

Tuberculosis Screening (see Tuberculosis Screening Information sheet)
- 2-step PPD screening (2 SEPARATE administrations of the PPD 1 to 3 weeks apart) within 3 months of starting school if no history of positive PPD test or disease (Please see instruction sheet)
- Chest X-ray within 6 months of starting school if history of positive PPD test or disease
- A QuantiFERON Gold TB blood test or T-Spot test is acceptable if history of positive PPD test and history of BCG vaccine documentation is available. Please turn in this documentation.

Recommended
Influenza Vaccine
- Will be available to students in the fall. This is strongly recommended and could become a requirement at a later date.

Meningitis Vaccine
- Please see http://www.cdc.gov/vaccines/vpd-vac/mening/who-vaccinate.htm to determine if you need this vaccine.

HPV Vaccine
- Recommended for males and females, 26 years or younger. A series of three vaccines.

Mail documents to: Pacific Health Services University of the Pacific • 3601 Pacific Avenue • Stockton, CA 95211-0197
HISTORY AND PHYSICAL (General or Entrance)

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. Have this completed on or after March 1, 2015.

STUDENT’S NAME: ___________________________ DATE: __________________________

DATE OF BIRTH: _______________ SEX: _____ STUDENT ID #: __________________________

ADDRESS WHILE ATTENDING DUGONI:
______________________________________________________________________________

PHONE NUMBER: _______________ DDS ☐ IDS ☐ Ortho ☐ AEGD ☐ Endo ☐ Oral Surgery ☐

PAST MEDICAL HISTORY:

1. Significant past health problems, major illnesses/injuries, surgeries, hospitalizations:
   ____________________________________________________________________________

2. Childhood Diseases:
   ____________________________________________________________________________

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

4. Drug allergies & reactions:
   ____________________________________________________________________________

FAMILY HISTORY:

1. Parents: ____________________________________________________________________

2. Siblings: __________________________________________________________________

SOCIAL HISTORY:

1. Employment: __________________________________________________________________________

2. 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:

1. Health recommendations: _______________________________________________________________________

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

3. 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 ___________________________
TUBERCULOSIS (TB) SCREENING

1. Have you had a positive TB (or PPD) test?
   a. If YES, have a chest x-ray performed no more than 6 months prior to July 2015. Turn in a copy of the chest X-ray report with the rest of your documents. Turn in documentation of INH treatment if possible (INH treatment involves taking medicine for 6 months to 9 months after a positive test). This will complete this requirement. If you have had a positive PPD test and a BCG vaccine, you may instead get a QuantiFERON Gold or T-spot blood test. If the blood test is positive, you must then have a chest x-ray performed. If the blood test is negative, this requirement is completed.
   b. If NO, go to #2

2. Have a TB (PPD) test placed by your provider. The test must be read by a provider or nurse within 48 to 72 hours of being placed. This must be done no more than 3 months prior to July 2015.
   a. If it is negative, go to step #3.
   b. If it is positive, have a chest x-ray performed no more than 3 months prior to July 2015. Turn in a copy of the chest X-ray report with the rest of your documents. You have completed this requirement. Discuss INH treatment with your provider. This will complete this requirement.

3. Have a SECOND TB (PPD) test placed by your provider 1 week after the first test was placed. The second TB test must be placed no more than 3 weeks after the first test. The test must be read by a provider or nurse within 48 to 72 hours of being placed.
   a. If it is negative, this will complete this requirement.
   b. If it is positive, have a chest x-ray performed no more than 3 months prior to July 2015. Turn in a copy of the chest X-ray report with the rest of your documents. You have completed this requirement. Discuss INH treatment with your provider. This will complete this requirement.

First PPD

Date administered ___/____/______  Date read ___/____/______  mm_________  Positive  Negative

Second PPD

Date administered ___/____/______  Date read ___/____/______  mm_________  Positive  Negative

Chest X-ray  (Please attach radiology report)

Date ___/____/______  Result __________________________________________________

Blood Test (QuantiFERON or T-spot)  (Please attach lab report)

Date ___/____/______  Result: Positive  Negative

Name ___________________________  ID #_________________  DOB _____________

Please provide the name of your medical practice, address, phone number and fax number. You may use a stamp containing this information.
Hepatitis B Requirement for Health Science & Athletic Training Students

This protocol applies to the following students:

- Dental students and residents
- Dental Hygiene students who have entered the dental hygiene portion of the program
- Athletic Training students – juniors and seniors
- Pharm-D students
- Physical Therapy students
- Speech/Language Pathology – all students

READ ALL OF THE STEPS. FAILURE TO DO SO MAY RESULT IN NOT COMPLETING THE REQUIREMENTS.

- Students must present immunization records showing three Hepatitis B vaccines placed at 0, 1 month and 6 months. Some students may not have these records so a positive titer will meet the requirement. The series of three Hepatitis B vaccines should be started immediately if the student never had the vaccines.

- After completing all three vaccines (recently or in the past), **ALL STUDENTS MUST HAVE A HEPATITS B SURFACE ANTIBODY TITER (HBsAb)** drawn at least 1 month after the completion of the series. Students must have the titer drawn even if they have had the 3 vaccines.

- If the titer is **POSITIVE/IMMUNE** then the requirement is completed.

- If the titer is **NEGATIVE/NON-REACTIVE/NON-IMMUNE** then the student must complete one of the two following steps:
  1. If the student has documentation showing 3 previous Hepatitis B vaccines at some point in time, the student should receive one (1) Hepatitis B vaccine and be re-tested for the Hepatitis B Surface Antibody Titer (HBsAb) at least one month later. **The series of 3 vaccines should not be repeated. The student will be required to get the titer after the fourth vaccine even if he/she wants to complete the entire series of three vaccines.** However, if the student is negative for the second titer, then the student must complete vaccines #5 and #6 (see the next step.)
  2. If the student does not have documentation of ever receiving all three vaccines, the series of 3 vaccines should be given at 0, 1 and 6 months. The titer must be repeated 1 one month after the third vaccine. This option should not be followed for students who have 3 documented Hepatitis B vaccines.

- If the second titer is **NEGATIVE/NON-REACTIVE/NON-IMMUNE** then the student must complete one of the following steps:
  - If the student had the fourth vaccine and then a negative titer, administer the fifth vaccine immediately and the sixth vaccine in 5 months. Repeat the titer one month after the sixth titer. If this titer is negative, then test the student for Hepatitis C antibodies and Hepatitis B Surface Antigens. Consult with Pacific Health Services about follow-up.
  - If the student did the series of 3 vaccines and the titer is negative, then test the student for Hepatitis C antibodies and Hepatitis B Surface Antigens. Consult with Pacific Health Services about follow-up.