

PACIFIC UNIVERSITY

Health Profession Immunization and History Form

Please indicate your program:

<input type="checkbox"/> Dental Health Science	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Optometry
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> School of Professional Psychology/MA Counseling		

Did you attend Pacific University as an undergrad? No ___ Yes ___ Last name if different: _____

Confidential Health Report Information: Health report information is protected and confidential and is not a part of your University or Program educational record.

Name _____ DOB: _____
(Please print clearly) Last First Middle

Address _____ City _____ State _____ Zip _____
 Phone # _____ Cell # _____ Male/Female (circle one) Marital Status _____ # of Children _____

Person to be notified in an emergency _____ Relationship _____
 Phone # _____
 Address _____ City _____ State _____ Zip _____

Medications: List any medicines you take regularly, including over the counter medications/supplements _____

Allergies: Are you allergic to any medicines or latex? Yes No If yes, please list _____

Ongoing medical or psychiatric/emotional problems: _____

Personal Medical History

Please check any current or past medical problems listed below.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies (food, drugs, other) | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Cardiovascular/heart disease | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Blood clots/phlebitis | <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Dizziness/fainting |
| <input type="checkbox"/> High BP/cholesterol | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recurrent tonsillitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Anemia or other blood disorder | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Asthma/hay fever | <input type="checkbox"/> Thyroid disorder/problems | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis | |

Hospitalizations/Surgeries (Date & Description) _____

Personal Habits

Do you use tobacco? Yes No Smoke Chew If yes, how much? _____
 Do you drink alcohol? Yes No If so, how much? _____
 Have you ever used street drugs? Yes No If yes, what type and how much? _____

Family Medical History

Please mark the following if there is a history in your immediate blood relatives, e.g. parents, siblings or grandparents.

Yes No	Relationship	Yes No	Relationship
<input type="checkbox"/> <input type="checkbox"/> Breast Cancer	_____	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	_____
<input type="checkbox"/> <input type="checkbox"/> Colon Cancer	_____	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> <input type="checkbox"/> Other Cancer	_____	<input type="checkbox"/> <input type="checkbox"/> Asthma	_____
<input type="checkbox"/> <input type="checkbox"/> Cardiovascular Disease	_____	<input type="checkbox"/> <input type="checkbox"/> Depression/Anxiety	_____
<input type="checkbox"/> <input type="checkbox"/> High BP/Cholesterol	_____	<input type="checkbox"/> <input type="checkbox"/> Suicide	_____
<input type="checkbox"/> <input type="checkbox"/> Stroke/Heart Attack	_____	<input type="checkbox"/> <input type="checkbox"/> Other Mental Health Problems	_____
<input type="checkbox"/> <input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> <input type="checkbox"/> Alcoholism	_____

Please return your completed form in the enclosed Health Report envelope to Student Health Services, 2043 College Way, Forest Grove, OR 97116. Phone: (503) 352-2269 or fax to 503-352-3105.

Health Center Office Use/Reviewed Date & Provider:		
_____	_____	_____

Please complete Immunization Record on following pages

Immunization Record (Page 1)

(Immunization record information will be shared with your program – please sign release on page 4)

Please indicate your program:

<input type="checkbox"/> Dental Health Science	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Optometry
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> School of Professional Psychology/MA Counseling		

Name – Please print (last, first, middle initial)

Birth date (mo/day/yr)

IMPORTANT (PLEASE READ CAREFULLY)

Your program **REQUIRES** the following immunizations and titers before entering a health profession program at Pacific University. Please complete this form **AND** provide copies of proof of vaccinations, titer lab results, or statement from medical provider for medical exemptions (**BE SURE TO RETAIN ORIGINALS AND KEEP THEM WITH YOU AS YOU WILL NEED THEM OFTEN DURING YOUR PROGRAM**).

****Please contact your program if you have questions regarding immunization requirements**

1. MMR (Measles/Mumps/Rubella) vaccine Dates of immunization are needed below unless you are providing a copy of your rubeola, mumps **and** rubella antibody titers which indicate immunity.

1st MMR Vaccine. Month/Day/Year _____ (Must be received **after** first birthday).

2nd MMR Vaccine. Month/Day/Year _____ (2nd dose must be at least 30 days after 1st dose)

Please check one of the following statements:

_____ A copy of my immunization record is attached.

OR

_____ My rubeola, mumps **and** rubella antibody titers are attached that indicates I am immune.

Student Signature _____ **Date** _____

Exemptions to MMR Requirement:

I meet one of the following exemptions and thus do not need the MMR immunization:

(Check ONE)

_____ A signed physician/nurse practitioner/physician assistant statement is attached verifying I have had a medical reason for not receiving the measles immunization (i.e. anaphylactic reactions to eggs, or immunocompromised state, etc.).

_____ I am an adherent to a religion the teachings of which are opposed to immunization and I request that I be exempted from this required immunization.

I understand that I may be exposed to the measles, mumps or rubella virus during my program, and despite this risk, I decline the MMR vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring measles, mumps or rubella. In the event of an outbreak, I understand I may be excluded from the university under the direction of the local health officer or the Student Health Center Director. I also agree to defend, indemnify, and release the university from any and all claims resulting from my failure to receive the MMR vaccine. **In addition, clinical training sites may not allow my participation if I do not have the MMR vaccine.**

Student Signature for MMR Exemption: _____ **Date:** _____

2. Td/Tdap--Please meet one of the requirements below.

(Check ONE)

Tetanus/Diphtheria (Td) A dose received within the past 2 years is acceptable. Date of last TD _____ A copy of documentation is attached.

OR (if Td is more than 2 years old, one dose of Tdap is required)

Tetanus-Diphtheria-Pertussis (Tdap) According to the CDC, healthcare workers who have direct patient contact in hospitals or clinics should get **one** booster dose of Tdap as an adult. A 2 year interval since the last Td is suggested. Date of Tdap _____ A copy of documentation is attached.

(Continue on page 2)

Immunization Form (Page 2)

Name (last, first, middle initial)

Birth date (mo/day/yr)

Exemption to Td or Tdap vaccine (continued from page 1):

I meet the following exemption and thus do not need the Td or Tdap vaccine:

(Check ONE)

_____ A signed physician/nurse practitioner/physician assistant statement is attached verifying I have a medical reason for not receiving the immunization (i.e. severe allergic reaction to Diphtheria-Tetanus-Pertussis).

_____ I am an adherent to a religion the teachings of which are opposed to immunization and I request that I be exempted from this required immunization.

Exemption to Td or Tdap vaccine:

I understand that I may be exposed to Tetanus, Diphtheria, or Pertussis during my program, and despite this risk, I decline the Td/Tdap vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Tetanus, Diphtheria, or Pertussis. I also agree to defend, indemnify, and release the university from any and all claims resulting from my failure to receive the Td/Tdap vaccine. **In addition, clinical training sites may not allow my participation if I do not have the Td/Tdap vaccine.**

Student Signature for Td or Tdap Exemption: _____ **Date:** _____

3. TB (Tuberculosis) skin test: Tb test must be within 1 year prior to entering Pacific University

Date of TB skin test _____

Result of TB Test

Negative _____ A copy of my result is attached

Positive (**see additional information needed below**)

1. If TB skin test is positive, attach copy of TB skin test and Chest X-ray report (X-Ray must be within the past 2 years)

Date of X-ray _____ Result _____

4. Hepatitis B virus (HBV) vaccine (Series of 3 vaccines).

_____ 1st Dose Mo/Yr _____ 2nd Dose Mo/Yr _____ 3rd Dose Mo/Yr _____ Titer (2 months after 3rd dose)

Please check ONE of the following statements:

_____ I have completed the Hepatitis B vaccine series (three doses) and a copy of my Hepatitis B antibody titer is attached which indicates that I am immune to Hepatitis B.

_____ I am in the process of completing the Hepatitis B series and will provide a copy of my Hepatitis B antibody titer after completion of the series. Date of scheduled next dose: _____

Exemptions to Hepatitis B Requirement:

I meet one of the following exemptions and thus do not need the Hepatitis B immunization:

_____ A signed physician/nurse practitioner/physician assistant statement is attached verifying I have a medical reason for not receiving the Hepatitis B vaccine.

_____ I am an adherent to a religion the teachings of which are opposed to immunization and I request that I be exempted from this required immunization.

I understand that I may be exposed to the Hepatitis B virus (HBV) during my program, and despite this risk, I decline the Hepatitis B vaccination at this time. I also agree to defend, indemnify, and release the university from any and all claims resulting from my failure to receive the HBV vaccine. **In addition, clinical training sites may not allow my participation if I do not have the Hepatitis B vaccine.**

Student Signature for HBV exemption _____ **Date:** _____

(Continue on page 3)

Immunization Form (Page 3)

Name (last, first, middle initial)

Birthdate (mo/day/yr)

5. Varicella (Chickenpox) Dates of immunization are needed below unless you have had varicella and are providing copy of varicella titer indicating immunity. If titer does not reflect immunity, immunizations will be required.

Please check **ONE** of the following statements:

- _____ I have completed the immunizations series (see dates below) and documentation is provided. No titer is required.
- _____ I had varicella and attached is a copy of my varicella titer which indicates that I am immune to varicella.
- _____ I am in the process of completing the varicella immunization and will provide documentation of immunization upon completion. Date of scheduled completion: _____

1st Dose Mo/Yr

2nd Dose Mo/Yr

Exemptions to Varicella Requirements:

I meet one of the following exemptions and thus do not need the varicella immunization:

- _____ A signed physician/nurse practitioner/physician assistant statement is attached verifying I have a medical reason for not receiving the varicella immunization.
- _____ I am an adherent to a religion the teachings of which are opposed to immunization and I request that I be exempted from this required immunization.

I understand that I may be exposed to the varicella virus during my program, and despite this risk, I decline the vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the varicella virus. I also agree to defend, indemnify, and release the university from any and all claims resulting from my failure to receive the varicella vaccine. **In addition, clinical training sites may not allow my participation if I do not receive the varicella vaccine.**

Student Signature for Varicella Exemption: _____ **Date:** _____

6. Hepatitis A virus (HAV) vaccine (Series of 2 vaccines).

NOTE - Hepatitis A vaccination is **REQUIRED** for International Travel and **STRONGLY RECOMMENDED** for all health profession students.

1st Dose Mo/Yr

2nd Dose Mo/Yr

Please check **ONE** of the following statements:

- _____ I have completed the Hepatitis A vaccine series (two doses) and a copy of my immunization record is attached.
- _____ I am in the process of completing the Hepatitis A series and will provide a copy of my immunization record after completion of the series.

Exemptions to Hepatitis A Requirement:

I meet one of the following exemptions and thus do not need the hepatitis immunization:

- _____ A signed physician/nurse practitioner/physician assistant statement is attached verifying I have a medical reason for not receiving the Hepatitis A vaccine.
- _____ I am an adherent to a religion the teachings of which are opposed to immunization and I request that I be exempted from this required immunization.

I understand that I may be exposed to the Hepatitis A virus (HAV) during my program, and despite this risk, I decline the Hepatitis A vaccination at this time. I also agree to defend, indemnify, and release the university from any and all claims resulting from my failure to receive the HAV vaccine. **In addition, clinical training sites may not allow my participation if I do not have the Hepatitis A vaccine.**

Student Signature for HAV exemption _____ **Date:** _____

(Continue on Page 4)

Immunization Form (Page 4)

Name (last, first, middle initial)

Birth date (mo/day/yr)

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**AUTHORIZATION TO DISCLOSE IMMUNIZATION RECORDS**

**I hereby direct:** Pacific University Student Health Center

**To release my immunization, titer, x-ray, and exemption information to my program:**

- A summary of immunization records, titers, chest x-rays reports (in cases of positive TB test), and medical and religious exemptions.

**For the Purpose of: Information required for program and clinical sites**

This authorization may be revoked by student at any time with written notification to the Student Health Center at the address below. Unless revoked earlier, this consent will remain in effect as long as student is enrolled at Pacific University.

**Student Signature for Release** \_\_\_\_\_

\_\_\_\_\_  
Date

**I DO**    **I DO NOT**   Consent to the transmission of medical records via facsimile (fax) machine with the understanding that the confidentiality at the receiving end cannot always be guaranteed.

**Please return these forms, and copies of proof of vaccine  
with the Health Report in the envelope provided or mail to:**

**Student Health Services, Pacific University, 2043 College Way, Forest Grove, OR 97116  
Phone # (503) 352-2269      FAX # (503) 352-3105**