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Student Health and Immunization Requirements[1]

Responsible Party	Program Director and Principal Faculty
Minimum Review Frequency	Annual
Associated Forms	See Appendix A
ARC-PA Associated Standards	A3.07, A3.19, A3.21
Initial Effective Date	10/29/2018
Last Review Date	10/29/2018
Approved by	• Principal Faeulty Representative Signature____ • Program Director Signature____ • D_ean of tl't'e Division of Appli¢, Signature____ • Provost'. Signature____
Next Review Date	09/01/2020

Rationale:
The Pfeiffer University Master of Science in Physician Assistant Studies (MS-PAS) program considers the health, safety and welfare of its faculty, student body, staff and the community we serve of utmost importance. Therefore, based on the Centers for Disease Control Recommended Vaccines for Healthcare Workers most recent guidelines; the program has developed the following policy in order to safeguard the wellbeing of all.

Policy:

Health Requirements

- Required Drug Screen
  - All students who have been offered conditional acceptance must successfully pass an initial chain of custody drug screen.
  - All matriculated students must complete and successfully pass a second chain of custody drug screen upon completion of the didactic phase prior to entering the clinical phase of the program.
  - Additional chain of custody drug screens and "for cause" testing for any student suspected of being under the influence of unlawful drugs or alcohol during their course of study. Reasonable for cause drug testing, is performed when a faculty member and/or clinical preceptor have evidence or reasonable cause to suspect a student of alcohol or drug use. Evidence is based upon direct observation, either by a faculty member or a clinical preceptor. Specific reasons for "for cause" testing include physical evidence of illicit substances, patterns of erratic or abnormal behavior, disorientation or confusion and an inability to complete assigned tasks.

- A student may be prevented from progressing in the program's didactic phase, being promoted to the clinical phase of the program, or being recommended for graduation if the student fails a chain of custody drug screen. Therefore, the Pfeiffer University MS-PAS program reserves the right to withdraw offers of conditional acceptance if the candidate fails the initial chain of custody drug screen.

- Required Physical Examination
    - A comprehensive physical examination by a licensed medical provider (DO, MD, PA or NP) must be completed indicating that the conditionally accepted applicant is appropriately screened for TB, current on all immunization requirements, and has been medically cleared for admission.
        - The Student Health Packet includes instructions and the following forms:
            - Medical History
            - Physical Examination
            - Immunization Verification*
            - Chain of Custody Drug screen
    - All students must have a second physical examination conducted by licensed medical provider (DO, MD, PA, or NP) prior to starting the clinical phase of the program indicating that the conditionally accepted applicant is appropriately screened for TB, current on all immunization requirements, and has been medically cleared for admission.
        - The Student Health Packet includes instructions and the following forms:
            - Medical History
            - Physical Examination
            - Immunization Verification*
            - Chain of Custody Drug screen

Immunizations
Immunization requirements based on the most current standards set by the Center for Disease Control (CDC).

All students must complete the following requirements prior to matriculation:

- **Tuberculosis (TB) Screening**:
    - The student must submit documentation of ONE of the following:
        - Results of NEGATIVE "Two-Step" TB Skin Testing (TST/PPD)
            - This screening requires 2 separate TB skin tests administered at least one week apart but within 12 months of each other.
            - The last TST must be within 6 months of your start date.
        - Lab Copy showing a "NEGATIVE" Interferon Gamma Release Assay (IGRA) blood test (QFT or T-Spot) within 6 months of start date (accepted in lieu of the "Two-Step" TST).
    - Individuals with a history of a POSITIVE TB skin test or IGRA blood test must submit both of the following:
        - Verification of a NEGATIVE Chest X-ray within 12 months of start date and
        - A current NEGATIVE Screening Questionnaire

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- **Rubella (German Measles):**
    - Serologic documentation of a positive Rubella immune titer OR immunization with at least one dose of live Rubella or MMR vaccine after 12 months of age.

- **Measles (Rubeola):**
    - Serologic documentation of a positive Rubeola immune titer OR immunization with two doses of live Rubeola or MMR vaccine administered after 12 months of age and separated by 28 days or more

- **Mumps:**
    - Serologic documentation of a positive Mumps immune titer OR immunization with at least two doses of live Mumps or MMR vaccine after 12 month of age.

- **Varicella (Chicken Pox):**
    - Serologic documentation of a positive Varicella titer OR two Varicella immunizations (given 4 to 8 weeks apart).
    - This requirement is satisfied only by a positive titer or the vaccine series.

- **Hepatitis B "Positive" Quantitative Surface Antibody Titer (Blood Test)**:
    - Serologic documentation of a Positive (QUANTITATIVE) Hepatitis B surface antibody titer that verifies IMMUNITY to the Hepatitis B Virus.
    - The TITER is required in addition to completion of the vaccination series.
    - The results should be reported as "POSITIVE" or as a number.
    - "REACTIVE" results will NOT be accepted.

- **Adacel™Or Boostrix® Vaccine Booster:**
    - Documentation of an Adult TETANUS/diphtheria/acellular pertussis (Tdap) vaccine booster is required.
    - Tdap was licensed in June, 2005 for use as a single dose booster vaccination (i.e. not for subsequent booster doses).
    - The current CDC recommendation states "Healthcare personnel, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose".

- **Meningococcal Vaccination:**
    - Documentation of immunization with one dose of Meningococcal vaccine after 16th birthday

All matriculated students MUST present evidence of the following on an annual basis during their tenure with the program:

- **TB screening**
- **Influenza vaccine**

Students are financially responsible for the cost of all health care services they may require while enrolled in the program, including any health care services required as a result of their participation in scheduled

program activities (e.g. TB testing, immunizations, treatment of injuries, pathogen exposure evaluation and treatment). Students are also required to sign a Health Screening and Immunization Information Release Form.

Noncompliance with any component of this policy will result in withholding the student from progressing in the program, withdrawal from classes without credit and a referral to the Academic Review Committee.

The program will maintain the immunization records of all matriculated students through a HIPPA compliant, secure cloud based management system. All records will be reviewed by the Director Clinical Education and the Admissions Support Coordinator upon acceptance into the program and annually thereafter throughout the student's tenure with program. The Director of Clinical Education will also continuously review the Centers for Disease Control Recommended Vaccines for Healthcare Workers guidelines and recommendations for updates.

Review
This policy will be reviewed at the annual program retreat.

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Appendix A
Student Health Requirements

In accordance with the policies set forth by the Pfeiffer University Master of Science in Physician Assistant Studies (MS-PAS) program all students must complete the following health requirements prior to the commencement of classes in order to comply with matriculation standards. Failure to comply with these mandated requirements will result in a hold being placed on your record preventing registration until requirement is met. (For more information regarding the Pfeiffer University MS-PAS Program Health Requirements please refer to the Pfeiffer University MS-PAS Student Handbook).

All accepted students will be given access to a secure HIPPA compliant web based data management system (E-medley). Students MUST submit all required health forms and complete all the electronic fillable forms into their E-medley account.

Students are financially responsible for the cost of all health care services they may require while enrolled in the program, including any health care services required as a result of their participation in scheduled program activities (e.g. TB testing, immunizations, treatment of injuries, pathogen exposure evaluation and treatment). Students are also required to sign a Health Screening and Immunization Information Release Form.

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Appendix A

Student Information

Name: ____

Pfeiffer University Student ID#: ______________________

Date of Birth: _______ _____ _____
(Month) (Day) (Year)

Gender: ☐ Male ☐ Female

Email: _____________________________

Cell Phone: (_____) _________________________

Home Phone: (_____) ________________________

Local Address: ____
Street City State Zip

Emergency Contact:

Name: ______________________________ Relationship: ____________________________

Address: ____
Street City State Zip

Contact Number: (____) ______________________

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Health Requirement Checklist

Please check box once you have uploaded the respective documentation to your E-medley account; upload both sides of document where applicable.

☐ **Health Insurance**
All Pfeiffer University MS-PAS students must have valid health insurance coverage for the duration of the program. The policy must meet the basic minimum benefits, cover the entire academic year and must be renewed annually.

☐ **Disability Insurance**
All Pfeiffer University MS-PAS students must have valid Disability Insurance coverage to cover injuries that might result in chronic disability during their educational training period.

☐ **Health Provider Attestation Statement**
All Pfeiffer University MS-PAS students must submit the official form signed and dated by their healthcare provider.

☐ **Immunization**
All Pfeiffer University MS-PAS students are required to meet the immunization requirements listed in the Pfeiffer University MS-PAS Student Handbook. Students must also receive an annual flu vaccine or submit the appropriate waiver form from the Pfeiffer University MS-PAS program.

☐ **Drug Screening**
All Pfeiffer University MS-PAS Students are required to submit results of a ten panel + alcohol drug screening prior to the start of the Didactic and Clinical year.
Drug screening packages can be purchased through E-medley (see Price Sheet for more information).

☐ **Background Check**
All Pfeiffer University MS-PAS students are required to submit a Level II background check prior to the start of the Didactic and Clinical year.
Background checks can be purchased through E-medley (see Price Sheet for more information).

☐ **BLS and ACLS**
All Pfeiffer University MS-PAS students must submit a copy of current BLS upon admission to the program. Students must have BLS, ACLS and PALS to attend clinical rotations. (ACLS and PALS training and certification will be provided by the Pfeiffer University MS-PAS program)

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SECTION I: Health Insurance Verification

Name: ___________________________________ **Sex**: ☐ Male ☐ Female

Pfeiffer ID: _________________

Email: _________________________________ **Date of Birth**: ____/___/____

Cell phone: ________________

Do you have current Health Insurance? ☐ Yes ☐ No

PART A: Insurance Policy Information

Name of Insurance Company: ____

Policy #: __________________________ Group #: ___________________________

Type of Insurance: ☐ PPO ☐ HMO ☐ Indemnity ☐ Other ☐ Unknown

Effective Date: ____________________

Expiration Date: _____________________

Name of Insured or Policy Holder: ________________________________

Relationship to Student: ________________________

PART B: Verification and Statement of Financial Responsibility
Verification of your insurance coverage may be made by one of the following ways:

☐ Photocopy of valid insurance card (Upload a copy of this document to your E-medley account along with this form).

☐ Photocopy of your insurance policy that demonstrates uninterrupted coverage for an entire year (Upload this proof to your E-medley account with this form).

SECTION II: Disability Insurance Verification

Name of Insurance Company: ____

Policy #: ________________________

Group #: _________________________

Type of Insurance:

Effective Date: ___________________

Expiration Date: ____________________

Name of Insured or Policy Holder: ____________________

Relationship to Student: __________________

I, ____, hereby certify that I am personally covered by health insurance or an equivalent health care plan as required by Pfeiffer University Master of Science in Physician Assistant Studies (MS-PAS) program. If the Pfeiffer University MS-PAS determines that the above coverage does not comply with the basic health insurance requirement, I understand and agree that the Pfeiffer University MS-PAS program may charge my University account for health insurance coverage, and I agree to pay all such charges in accordance with University policy. I understand and agree that I will be responsible for any and all charges for health care services regardless of whether or not covered by insurance or an equivalent plan. I further understand and agree that the Pfeiffer University MS-PAS and all of its representatives will not be responsible for paying for or providing any medical/hospital care or health insurance coverage for me.

The above information is requested for the purpose of compliance with the health insurance requirement for the Pfeiffer University MS-PAS students. The information will only be used by the Admissions Coordinator for the purpose of identifying and evaluating health care financial responsibility information in accordance with established requirements and will not be released to any party outside the Pfeiffer University MS-PAS without my written permission, except as permitted by law.

I understand and agree that I must complete this form at the start of each academic year and whenever my health insurance coverage changes for any reason.

Signature: ______________________________ Print Name: ______________________________

Date: _________________________________

SECTION III: Health Provider Attestation Statement

NOTE: The only healthcare providers authorized to sign the Health Provider Attestation Statement are physicians (MD and DO), nurse practitioners and physician assistants. This document must be from a physician's office, urgent care center, or outpatient clinic and must contain the practice office location and phone numbers.

Student Name: ___________________________________

Student Email: ___________________________________

Student Phone: ___________________________________

Based on medical history and physical examination, this student is cleared to participate in all aspects of the Pfeiffer University MS-PAS program, including direct patient contact.

☐ Yes
☐ No
☐ Yes, pending (only applies to Immunizations and TB screening processes)
____
____

Healthcare Provider Signature: ____________________________________

OFFICE STAMP:

Please Print:

Name of Physician: ______________________________ Date: __________

Office Address: ____

Office Phone: ____

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SECTION IV: IMMUNIZATION

Name: _________________ **Sex**: ☐ Male ☐ Female **Email**: _______________ **Phone Number**:_______________

Vaccine and Immunity Verification
(To be completed by a health care provider)

Vaccine / Test	Dates Vaccine Administered (Month/Day/Year)				Attach required documents
MMR (Measles, Mumps, Rubella) (Provide serologic documentation of antibody titers for all three viruses **AND** 2 MMR vaccine doses (if applicable)	___ /___ / ____	___ /___ / ____			**REQUIRED** Antibody titer results and date(s) Rubella: Rubeola (Measles): Mumps:
Hepatitis B (Provide serologic documentation of positive Hepatitis B surface antibody titer (IgG quantitative); if negative begin 3 dose vaccine series and redo titer after 6-8 weeks)	___ /___ / ___	___ /___ / ____ (1 month after first vaccine)	___ /___ / ____ (6 months after first vaccine)		**REQUIRED** Serologic titer result and date(s) Hepatitis B Surface Antibody titer (IgG quantitative) Positive:
Tetanus / Diphtheria / acellular Pertussis (Tdap)	___ /___ / ____ (Provide documentation of Td (Tetanus/diphtheria) booster within last 2 years; if Td was received more than 2 years ago, then Tdap is required)				N/A
Polio (4 doses recorded from childhood if applicable or provide serologic documentation of titer)	___ /___ / ____	___/___/___	___ /___ / __	___ /___ / __	Serologic titer required if dates of all 4 polio doses are not complete. Titer result/date:
Varicella (Chicken Pox) (Positive Varicella serologic IgG titer or 2 vaccine doses given 4-8 weeks apart)	___ /___ / ____	___ /___ / ____			**REQUIRED** Varicella lgG titer result and date ____________________
Meningitis (Meningococcal) (one dose required)	___ /___ / ____				N/A
2-Step Tuberculosis Skin Test (PPD) (Chest X-Ray required if PPD is positive)	___ /___ / ____	___ /___ / ____			**<u>If +PPD:</u>** Need chest X-ray results within past 12 months and written

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		(to be done 7-28 days after first skin test)	clearance from authorized health provider.
For Hepatitis B & Varicella: Copies of actual lab test results indicating positive serum antibody titers are required as proof of immunity. When vaccine series is incomplete, dates of vaccination should be provided on this form until the time when serum antibody titers are done to prove vaccine-induced immunity.			

(To be completed by Healthcare Provider)

HEALTHCARE PROVIDER ATTESTATION STATEMENT:

This section must be completed and signed.

Based on the above immunization documentation, this student is cleared to participate in all aspects of the Pfeiffer University MS-PAS program, including direct patient contact.

☐ Yes ☐ No

☐ Yes temporarily, pending completion of the following recommendations pertaining to immunity status:

Recommendations (vaccines/titers still needed with dates of required completion:
____
____

Healthcare Provider Signature: ________________________________

OFFICE STAMP:

Please Print:

Name of Physician: ___________________________ Date: _________

Office Phone: ____

Office Address: ____

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SECTION V: TUBERCULOSIS SCREENING QUESTIONNAIRE

(Only complete this section if you are PPD Positive)

Student Name: ______________________

Date:______________________

	YES*	NO
Has anyone in your family or close contact had tuberculosis (TB)?	☐	☐
Have you ever been on medication to treat TB?	☐	☐
Have you ever had a BCG vaccination? If yes, when? Date: ________________	☐	☐
Have you had any of the following symptoms in the past month?	☐	☐
Chronic Cough (more than three weeks)	☐	☐
Fever/Chills	☐	☐
Unexplained weight loss	☐	☐
Excessive fatigue or weakness daily	☐	☐
Spitting or coughing up blood	☐	☐
Night sweats	☐	☐
Loss of appetite	☐	☐

(If your PPD test is positive, this form must be completed annually in lieu of receiving annual Chest X-rays.)

*Please explain any “Yes” responses below – continue on a separate sheet if necessary.

____

____

The information I have provided in this form is accurate to the best of my knowledge. I acknowledge that the Pfeiffer University Master of Science in Physician Assistant Studies program is not responsible for any information I omit.

Signature of Student: ____

Date: ____

Healthcare Provider Signature: _________________________________

OFFICE STAMP:

Please Print:

Name of Physician: ____________________________ Date: _________

Office Phone: ____

Office Address: ____

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SECTION VI: Health and Safety Agreement

I agree to fulfill and provide documentation of all health and safety requirements listed below. All pre-matriculation forms (e.g. the "Medical History and Physical Examination" form, "Health Insurance Verification" form, the "Immunization Documentation" form, and this form all must be scanned and uploaded directly to the E-medley website for the Pfeiffer University Master of Science in Physician Assistant Studies (MS-PAS) program. The Admissions Coordinator will receive notification from E-medley regarding my compliance status. If vaccine information or medical testing is incomplete, I agree to comply with any requirements and submit documentation to E-medley as soon as possible. **All tests and at least the first dose of all vaccine series must be done prior to Orientation**. I also agree to comply with all annual and future health requirements that may be subsequently prescribed by the Pfeiffer University MS-PAS designed to protect my health.

Ongoing Annual Health Requirements:

- ✓ **Health Insurance**: I will purchase and maintain a healthy insurance policy for the duration of my enrollment in the Pfeiffer University MS-PAS program that meets the basic minimum requirements as set forth in the Pfeiffer University Master of Science in Physician Assistant Studies Student Handbook. I will not cancel this policy unless I provide proof of comparable coverage under an alternate acceptable policy and upload a revised "Insurance Verification Form" and copies of the insurance card to my E-medley online account. I agree to complete and upload this form before August 1st annually even if no changes to my health insurance have occurred.

- ✓ **Disability Insurance:** I agree to purchase Disability Insurance Policy and agree to renew it annually while enrolled as a student at the Pfeiffer University MS-PAS program.

- ✓ **Influenza Vaccine:** I agree to receive the influenza vaccine annually before October 31st unless I have medical contraindications. I agree to upload this documentation promptly to my E-medley online account.

- ✓ **TB Screening:** I agree to submit annual TB Screenings to my E-medley site, either
  A PPD Skin Test (if I'm PPD negative) or the TB symptom screening form signed by my physician (if I've tested PPD positive anytime in the past and have a negative chest X-Ray)

I freely provide this information and understand that non-compliance will result in my inability to participate in clinical activities until all requirements have been met; I also understand that this will negatively affect my academic performance which may lead to dismissal from the Pfeiffer University MS-PAS.

Name: ________________________________ Date: _____________________
(Print)

Signature: ____

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Section VII: Health Screening and Immunization Information Release Form

Student Name: ____

Date: ____

I ________________________________, hereby authorize the Pfeiffer University MS-PAS program to release all or part of my medical attestation, tuberculosis screening results, influenza vaccine documentation and immunization/titer records to the clinical sites to which I am assigned. I understand that all other medical records will remain confidential and will not be accessible to or reviewed by the Pfeiffer University MS-PAS program faculty or staff.

Student Signature:

Date: