



**Samuel Merritt
University**

**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
- **COVID-19 vaccines:** All students are required to have the following: 2 doses of Moderna, 2 doses of Pfizer, or single dose of Johnson & Johnson.
- **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 startday)*
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 insurancecoverage.
- **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

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

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)
- HIPPA 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 _____