Health Career Immunization Packet

WHAT is the Health Career Immunization Packet?

The Health Career Immunization Packet contains documents required for students who wish to participate in clinical experiences with Minnesota State Community and Technical College (M State) affiliated sites.

WHO should complete the packet?

Any student enrolled in an M State Health Career program participating in a clinical rotation should complete the packet.

WHEN should the packet be complete?

Each program identifies the due date for submitting the packet.

- Students should refer to program communications regarding specific due dates.
- All documents in the packet must be complete in order to be accepted.
- Student who turn in an incomplete packet will be required to resubmit the entire packet.

WHERE can the packet be submitted?

- Student must complete the packet electronically and submit it to the designated program representative.
- The program will identify how the packet should be turned in (assignment dropbox, hand deliver, etc.) and communicate that option to the student.
- Refer to the list below for program specific college representatives and due dates.

This packet includes the following documents that should be read/reviewed, completed, initialed, signed, and submitted:

- Verification of Policy & Release of Information
- Authorization to Release Student Information
- Emergency Contact Information
- Health Declaration Form
- Definitions and Explanations of Immunizations
- Exposure & Immunity Requirement Form

*Students in the following programs must **submit the complete packet** to the listed college representative by the due date.* *(The program reserves the right to update the due date, please refer to program information.)*

Program	College Rep	Due Date
Health Information Technology	Kim Samuelson/Bonnie Peterson	Prior to clinical rotation/see program info.
Medical Lab Technician	Teresa Beske	8 weeks prior to clinical rotation
Pharmacy Technology	Submit electronically with admission pkt.	Prior to program admission
Phlebotomy Technician	Teresa Beske	4 weeks prior to clinical rotation
Radiologic Technology	Amy Coley	Prior to clinical rotation/see program info.

- ***The student must complete the Health Career Immunization Packet electronically.***
- ***By typing their initials and electronically signing the documents, students confirm accuracy of the data and accept the requirements specified in the documents.***
- ***By signing the documents, students further indicate all information is complete and accurate, to the best of their knowledge.***
- ***Students are encouraged to print a copy of the document for their records.***

Verification of Policy & Release of Information

Read, type initials and electronically sign and date.

Statement of Student Responsibility/Confidentiality

I understand I have an obligation to conduct myself in a professional manner, follow all facility policy and procedures, and hold confidential all information concerning the patients/residents at clinical facilities. I understand the unique and personal nature of client care that is involved in the education of nurses and fully intend to safeguard the privacy of all clients for whom I give care as well as their families. I will not disclose information about my clients, their families or information about fellow students that may be obtained during my studies at M State. I understand that this confidentiality is essential in the health professions. I agree to adhere to the professional standards of confidentiality while enrolled in my program of study at M State. I understand any carelessness or thoughtlessness in release of any confidential information is not only ethically wrong, but may involve the clinical facility and myself legally. I may not be able to progress academically as a result of this.

Initial _____

Authorization for the Release of Background Information

I hereby authorize M State to release information contained in its files (including but not limited to reports, records and letters or copies thereof) regarding a background study performed by the Department of Human Services, or a request to the Commissioner of Health for reconsideration of a disqualification, to determine my eligibility to participate in clinical placements to fulfill the requirements of my program of study at M State. This information may be released to any of the facilities used for clinical experience. I understand that the facility will review this information to assess whether I may be permitted to participate in a clinical placement for my program of study. If background clearance is denied/not received by the Department of Human Services, I understand that I cannot participate in clinical courses until a background clearance is obtained. I understand that it is my responsibility to maintain a clear background check and to follow instructions within reconsideration of disqualification, including completing subsequent background checks without expiration.

I understand that I am not legally obligated to provide this information. If I do provide it, the data will be considered private data under state and federal law, and released only in accordance with those laws, or with my consent. I provide this information voluntarily and understand that I may revoke this consent at any time. A photocopy of this authorization may be used in the same manner and with the same effect as the original documents. This authorization is considered current from the date of my signature until the last date of my final clinical/practicum experience.

Initial _____

Immunizations

I understand that I am required to submit proof of vaccination and proof of titer showing immunity for all vaccines listed on the M State Exposure/ Immunity form. I further understand that this is a contractual requirement and if I choose not to supply this documentation, I will not be allowed to attend clinical and therefore may not be able to successfully complete my health career program.

Initial _____

Release of Hepatitis Liability

I agree to assume all risks in connection with immunization and fully release M State and all associated clinical facilities from all liability for any illness or damage to me due to receiving the vaccine or of my failure to receive the vaccine.

Initial _____

Release of Health Information

I understand that the college complies with the provisions for the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Therefore, in order to assure equal access to the full range of collegiate experiences in the most integrated setting, I must provide the college documentation of a disability to receive special services as outlined in the college handbook. If at any time, I am unable to perform the required technical standards I must be in contact with the director of disability services on my campus.

I grant M State permission to share information contained in the *Health Declaration* form and *Exposure and Immunity*

Requirements form with those clinical institutions with which I affiliate in my student role, should the clinical institution request or require it. I understand failure to sign this form or to provide the information requested could mean a clinical site may refuse me placement at their facility. The M State Program I am studying in does not guarantee an alternative facility placement. I also understand that if no alternative facility placement is available, I may be unable to progress in a health career program.

Initial _____

Responsibility for Health Care Costs

Any health care costs incurred during the period of time I am a student in a health career program will be my responsibility.

Initial _____

Workers' Compensation

It is the position of the clinical facilities and M State that, as a student, I am not an employee of either the clinical facilities to which I am assigned or M State for purposes of Workers' Compensation insurance.

Initial _____

Statement of Simulation Participation Expectations & Confidentiality

Learning objectives for simulation in health care education include but are not limited to the following: a) apply basic to complex health skills, b) improve critical thinking skills, c) recreation of high risk/low frequency skills, d) assist in development of leadership skills and teamwork, and e) provide instant feedback and situation debriefing.

Each simulation experience is meant to offer you an opportunity to experience a mock-up of possible clinical experiences you may encounter in various health care settings and environments. It is our expectation that you participate fully in these experiences and treat the environment and the patients in the simulation as though they are real patients.

The experience of simulation may evoke some unexpected actions, patient responses, and outcomes. Simulation learning activities are an opportunity to evaluate hospital systems, teamwork activities, as well as individual preparedness during various patient care situations and emergencies. At the end of many simulations, we will take time to debrief in small and/or large groups. This will be your opportunity to discuss how you feel the educational experience has gone and what possible improvements could be made as a system, team, or as an individual. Please be sensitive to your team members and do not share individual performance issues with other peers. We expect professional behavior and attire when in the health simulation lab (i.e., M-State Scrubs, stethoscope). Likewise, we expect confidentiality to be maintained so that we can facilitate a safe, structured learning environment for all health career students.

Students may be asked to randomly complete evaluation forms related to their simulation experiences. We appreciate your thoughtful responses regarding your perceptions related to the simulation experience and how we can make improvements for the future. I understand that instructors and peers may videotape me during simulations for learning outcome assessment purposes and educational review. I further grant permission to be photographed and/or videotaped and that these images may be disseminated for public relations reporting to the M-State Community and the community at large.

Initial _____

Authorization for Use and Release of Student Work

I hereby authorize M State to use and release copies of my student work (assignments, papers, and projects, etc.) for purposes of department accreditation.

Initial _____

Acknowledgement to Maintain Records:

Students are responsible to maintain currency and submit updated documentation prior to expiration to the designated college representative. Students who do not maintain program sequence or participate part-time may be required to resubmit all documentation. I ACKNOWLEDGE THAT I may be required to update and/or resubmit documentation upon expiration or if the program takes longer than outlined in the program plan.

Initial _____

Students are required to keep copies of all submitted documents. I ACKNOWLEDGE THAT I have been informed to maintain a copy of my health forms, immunization records an any other documents that may need to submit to perform my clinical experience.

Initial_____

I ACKNOWLEDGE THAT I understand that no division of M State can provide students with copies of their

records (other than educational) or required program paperwork.

Initial_____

I ACKNOWLEDGE THAT I have been informed that there is a record disposal policy for private data submitted to the college and these forms are destroyed as per the college policy for record disposal.

Initial _____

I ACKNOWLEDGE THAT I UNDERSTAND that failure to comply with the above listed required expectations may result in program probation and/or program removal.

Student ID # _____ Print Name_____

Student Signature _____ Date _____

Authorization to Release Student Information

Complete all information, read, electronically sign and date.

Student ID# _____

Last Name: _____ First Name: _____

Middle/Maiden: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

I hereby authorize Minnesota State Community and Technical College to release and/or orally discuss the education records described below about me to/with clinical partners of M State.

The specific records covered by this release include:

- Results of MN Department of Human Services background study
- Result of national background check (when applicable)
- Contact information
- Immunization record
- Birth date

Signature: _____ Date: _____

Minnesota State Community and Technical College

Emergency Contact Information

Complete all information.

STUDENT INFORMATION:

Student ID# ________________________

Last Name: ________________________________ First Name: ________________________

Address while Student: ____

City: _______________________________ State: ___________ Zip: _______________

Permanent Address: ____

City: _______________________________ State: ___________ Zip: _______________

Home Phone: __________________________ Mobile Phone: _________________________

Personal email address: ____

School email address: ____

~ ~

EMERGENCY CONTACT INFORMATION:

Contact Name:____

Relationship to student: ____

Address: ____

City: _______________________________ State: ___________ Zip: _______________

Home Phone: ____

Cell Phone: ____

Health Declaration Form

Complete all information, read, electronically sign, and date.

Program: Select Program Major

Campus Location: Select Campus Location _____

Student ID# _____

Last Name: _____ First Name: _____

Middle/Maiden: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____

Email Address: _____

Birthdate (mm/dd/yyyy):_____

Please read and sign

I certify that I have no known health conditions that would jeopardize my own or a patient's welfare and have no limitations that would restrict me from performing the customary duties of a health career student.

I understand that health career students are assigned in clinical areas where exposure to infection and communicable disease is common. My immune response or status is sufficient to allow assignment in all clinical areas and to all patients (assuming use of protective measures per facility policy).

I am able to perform the required technical standards (intellectual, psychosocial, motor, and environmental) for effective performance in Minnesota State colleges and universities health careers education programs.

I understand that health career students are exposed to latex products or chemicals, e.g. penicillin, etc. in the laboratory and clinical settings. If I currently have or develop an allergy, it is my responsibility to communicate to my instructor/lab assistant prior to each semester start and initiate appropriate precautions.

I understand that failure to sign this form or to provide the information requested in the Exposure and Immunity Requirements Form could mean that a clinical site may refuse my placement at their facility. The health career program does not guarantee an alternative facility placement. I also understand that if no alternative facility placement is available, I may be terminated from the health career program.

Signature: _____ Date: _____

Definitions/Explanation of Immunizations

Students should use the following information to identify the immunizations that must be documented on the *Exposure and Immunity Requirement* forms.

Tuberculosis -

Provide evidence that one of the following is complete no more than 60 days prior to program start.
Must be completed annually.

- *Fergus Falls Nursing program require no more than 60 days prior to start of Clinical.*
- *Pharmacy Technology program require completion during the program no more than 60 days prior to the start of clinical rotation.*

1. 2-Step Mantoux test
   MUST be completed no more than 60 days before start of program.
   - *The first step of a 2-Step Mantoux consists of having provider place tuberculin under skin and returning 48-72 hours later to have it read.*
   - *The second step the patient returns to the provider 2 weeks later and repeats step one.*
2. QuantiFERON tb Gold blood test-
   Must be completed no more than 60 days before start of Program
   Must be completed annually.
3. T-Spot Blood test-
   Must be completed no more than 60 days before start of Program
   Must be completed annually.
4. Positive Mantoux ,QuantiFERON tb Gold blood test or T-Spot blood test -
   Must provide documentation that therapy is completed
   Must provide proof of a clear chest x-ray.

Tdap-

Combination vaccine consisting of tetanus, diphtheria, and acellular pertussis.

1. Tetanus booster is required at least every 10 years.
2. Tdap –required at least 1 time between ages 11 and 64. Some providers use Tdap as tetanus booster.
   Please Note D tap is not the same as T dap and are not interchangeable.

Chicken Pox/Varicella-

1. Must have either received two (2) dose series of vaccine
   Or
2. Have a titer indicating immunity.
   *A history of chicken pox as a child is **NOT** acceptable proof of immunity.*

Hepatitis B-

Health career program students may be exposed to blood or other potentially infectious materials therefore may be at risk of acquiring the hepatitis B virus (HBV). Students are encouraged to discuss the hepatitis B immunization with their health care provider and strongly consider vaccination against hepatitis B.

1. You must have either the 3 dose series
   Or
2. Sign the declination statement.

MMR –

Is a combination vaccine consisting of Measles, Mumps, and Rubella.

- This is a two (2) dose series 28 days apart.
- If supporting documentation is not available, a titer is required to show immunity.

Influenza –

An annual Flu Vaccination is required.

- Submission of an updated vaccination may be required prior to or during the clinical experience depending upon when the vaccination was taken and if the site requires proof of yearly vaccination.

Exposure/Immunity Requirements
Tuberculosis/Mantoux

Mantoux tests must be read and documented by a licensed health care professional (nurse, nurse practitioner, physician assistant, or physician).

*Complete all information and attach **supporting documentation (REQUIRED).***

Student ID# _____ Last Name: _____

First Name: _____ Middle/Maiden: _____

☐ ___ *I am a Pharmacy Technology student and will submit proof of the Mantoux as directed during the program. (The Pharm Tech student may skip this form ONLY. It will be required closer to the clinical rotation.)*

☐ **2 Step Mantoux Results:**

Step 1: Date read: _____ Results: _____

Step 2: Date read: _____ Results: _____

OR

☐ **QuantiFERON tb Gold blood test/ T Spot Blood Test**

Date:_____ Results:_____

OR

☐ If at any time in the course of the student's life, he/she has documentation of the following:
Positive Mantoux, QuantiFERON tb Gold Blood Test or T-Spot Blood Test X-Ray

Date: _____ Result: _____

- *Physician documentation of a chest x-ray completed after becoming positive is required.*
- *Attach 1) positive Mantoux date and 2) chest x-ray completion date and result.*
- *Annual Mantoux testing is not required following positive Mantoux test.*
- *According to the CDC, repeat chest x-ray (after a positive Mantoux and negative chest x-ray) is not necessary unless there has been significant exposure to a person with TB or if you have any of the symptoms listed below.*
- *Please discuss your concerns with your health care provider (e.g. MD, FNP, PA).*

Positive Mantoux test and Negative chest x-ray:
Select any of the following symptoms you may be currently experiencing which may indicate active TB.

❒ Chronic cough of more than two weeks	❒ Loss of appetite
❒ Coughing up bloody sputum	❒ Fever/chills
❒ Night sweats	❒ Fatigue/Tire easily
❒ Unexplained weight loss	❒ Lethargy

Positive chest x-ray*
A student must attach proof of the physician's documentation of completed therapy for results of a positive chest x-ray.

Exposure/Immunity Requirements
Page 2 – All Immunizations (other than Mantoux)

_____, _____, _____, _____

Student ID # Last Name First Name Middle/Maiden

Tdap (diphtheria, tetanus, and acellular-pertussis)

Date of Tdap:_____ **Must have booster every 10 years**

Measles, Mumps & Rubella Immunity (MMR)

Check ☑ the **one** that applies to you:

☐ Born before January 1, 1957

■ Documentation of **two doses** of MMR vaccine after 12 months of age and at least one (1) month apart.

Date/ Dose 1:_____ Dose 2:_____

☐ Titer indicating immunity
Name of Titer indicating immunity _____ Date Titer read:_____

If pregnant and vaccination for rubella and/or rubeola and/or mumps is needed to meet immunity requirements, immunization must be received after delivery. Delivery date:_____

Chicken Pox (Varicella) *

Check ☑ your chicken pox status:

☐ Received Varicella vaccine

Date/ Dose 1: _____ Dose 2: _____

☐ Chicken pox titer indicates immunity

Date/ Titer Read: _____

***Please note a history of having had Chicken Pox is not sufficient. You must have a titer showing immunity or have had the Varicella series.**

Hepatitis B (Hep B)

Students are encouraged to discuss hepatitis B immunization with their health care provider (e.g. MD, FNP, or PA).

Check ☑ the response that represents you:

☐ I have COMPLETED the Hep B Series. Date completed: _____

☐ I am in PROCESS of completing the Hep B series.

Date/ Dose 1: _____ Dose 2: _____

☐ I have decided NOT to have the Hepatitis B Vaccine Series at this time following discussion with my health care provider (MD, FNP, or PA).

Influenza Vaccination

Annual Flu vaccination

Date: _____

Student Statement of Understanding and Release
Health Career Program

I, _____, am a student at Minnesota State Community and Technical
(type your name)

College Select Campus Locati enrolled in the health career program, _____.
(select campus location) (select health career program major)

I acknowledge that I have been informed and understand the following information:

1. The health career program I have enrolled in may involve exposure to human body fluids, cell, and tissue cultures that may carry infections such as HIV (Human Immunodeficiency Virus), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV).
2. Exposure to infectious blood and other body fluids and cultures by contract through eye, mouth, blood, non-intact skin, or other method may put me at risk of contracting a blood borne infection.
3. To protect myself from exposure to blood and other body fluid and cultures, I will wear protective apparel according to OSHA (Occupational Safety and Health Administration) standards and comply with applicable policies of the College and any hospital or clinical affiliate that I am attending.
4. If I should become exposed by eye, mouth, blood, non-intact skin, or other method to blood or other human fluids or cultures, I will immediately report such incident to program instructor or clinical affiliate supervisor.
5. If such exposure should occur, I hereby authorize the College or the clinical affiliate to administer such immediate first aid as is deemed appropriate until medical help can be obtained.
6. I hereby release and hold harmless Minnesota State community and Technical College, its employees, officers, agents, and representatives, including all hospital and clinical affiliates, from any liability for any and all injury, illness, disability, or death, including all costs for medical care, resulting from my exposure to infectious blood or other human fluids or cultures or the administration of emergency first aid after such exposure, during the course of my participation in the health career program, whether caused by the negligence of the college or otherwise, except that which is the result of gross negligence or wanton misconduct by the College.

Student Name: _____
(Type full name)

Student Signature: _____ Date: _____
(Follow directions for electronic signature) (Select todays date)

Instructor Signature: _____ Date: _____

Print