Minnesota State Community and Technical College

Verification of Policy & Release of Information Form

Student is to read, initial and sign where indicated; return to College Lab Assistant by assigned deadline.

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 myself and the clinical facility legally. This may result in my not being able to progress academically. **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 such time as 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 any and all liability for any illness or damage to me by reason of my 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 I may be videotaped during simulations for learning outcome assessment purposes and educational review by instructors and peers. 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** _____

CONSEQUENCES FOR FAILING TO COMPLY WITH THE ABOVE REQUIRED PROGRAM EXPECTATIONS WILL RESULT IN PROGRAM PROBATION AND/OR REMOVAL FROM THE PROGRAM.
STUDENTS ARE REQUIRED TO KEEP COPIES OF ALL DOCUMENTS SUBMITTED

- HEALTH FORMS
- IMMUNIZATIONS
- CPR
- NURSE AID.

STUDENTS WHO BECOME OUT OF SEQUENCE WILL BE REQUIRED TO RESUBMIT ALL DOCUMENTATION.
STUDENTS ARE RESPONSIBLE TO MAINTAIN CURRENCY AND SUBMIT UPDATED DOCUMENTATION PRIOR TO THE EXPIRATION OF IMMUNIZATIONS AND CPR TO THE NURSING COLLEGE LAB ASSISTANT. **Initial** _____

I ACKNOWLEDGE THAT I HAVE KEPT A COPY OF MY HEALTH FORMS AND IMMUNIZATIONS. **Initial** _____

I UNDERSTAND THAT THESE FORMS ARE DESTROYED (1) SEMESTER AFTER GRADUATION. **Initial** _____

I UNDERSTAND THAT THE M STATE NURSING PROGRAM DOES NOT PROVIDE STUDENTS WITH COPIES OF THEIR REQUIRED PROGRAM PAPERWORK. **Initial** _____

Student ID # _____

Print Name _____ **Student Signature** _____ **Date**_____

Authorization to Release Student Information

_____ _____, _____, _____
Student ID # Last Name First name Middle/maiden name

_____ _____ _____ _____
Address: Street/Box City State Zip code

_____ _____ _____
Home Telephone Mobile Telephone Email Address

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

The specific records covered by this release include:

- Result of National background check
- Results of MN Department of Human Services background study
- Contact information
- Immunization record
- Birth Date

_____ ____/___/___
Student Signature Date

Minnesota State Community and Technical College

Emergency Contact Form

Student ID #:_________________________

Student Name:____

Address while Student:____

City:__________________________ ST: ________ Zip: ___________

Permanent Address: ____

City: _________________________ ST: ________ Zip: ____________

Student Home Phone: ____

Student Cell Phone: ____

Personal Email:____

School Email: ____

~ ~

Emergency Contact:____

Address: ____

City: _________________________ ST: _______ Zip: _____________

Em. Contact Home Phone: ____

Em. Contact Cell Phone: ____

Relationship: ____

Health Declaration Form

Student is to complete this form; return to College Lab Assistant by the assigned deadline.

Program enrolled in: _____

Check (✓) location: ❒ Detroit Lakes ❒ Fergus Falls ❒ Moorhead ❒ Wadena ❒ eCampus

_____ _____, _____, _____
Student ID # Last Name First name Middle/maiden name

_____ _____ _____ _____
Address: Street/Box City State Zip code

_____ _____ _____
Home Telephone Mobile Telephone Work Telephone

Birth date (month/date/year): _____/_____/_____

Please read and sign

I certify that I have no known health conditions which would jeopardize my own or a patient's welfare and have no limitations which 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 come in contact with latex products or chemicals, e.g. penicillin, etc. in the laboratory and clinical. If I have or develop an allergy it is my responsibility to communicate to my instructor/lab assistant prior to beginning each semester 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 placement at their facility to me. 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_____

Minnesota State Community and Technical College

Definitions/Explanations

1. Tuberculosis- Must provide one of the following completed no more than 60 days prior to program start and annually:

   A. 2-Step Mantoux test-Must be completed no more than 60 days before start of program. Fergus Falls programs require no more than 60 days prior to start of Clinical. Must be completed annually.

      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. For the second step the patient returns to the provider 2 weeks later and repeats step one.

   B. QuantiFERON tb Gold blood test- Must be completed no more than 60 days before start of Program and must be completed annually.

   C. T-Spot Blood test- Must be completed no more than 60 days before start of Program and must be completed annually.

   D. If you have ever had a positive Mantoux ,QuantiFERON tb Gold blood test or T-Spot blood test you will need to provide documentation that you have completed therapy and have a clear chest x-ray.

2. Tdap- Combination vaccine consisting of tetanus, diphtheria, and acellular pertussis.

   A. Tetanus booster is required at least every 10 years.

   B. Tdap –required at least 1 time between ages 11 and 64. Some providers use Tdap as tetanus booster.

   C. Please Note D tap is not the same as T dap and are not interchangeable.

3. Chicken Pox/Varicella-Must have either received 2 dose series of vaccine or have a titer indicating immunity.

   A history of chicken pox as a child is ***NOT*** acceptable.

4. Hepatitis B- It is strongly recommended that students in the program be vaccinated against 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 hepatitis B immunization with their health care provider (e.g. MD, FNP, or PA). You must either have the 3 dose series or sign the declination statement.

5. MMR- A combination vaccine consisting of Measles, Mumps, and Rubella. This is a 2 dose series 28 days apart. If supporting documentation is not available a titer is required to show immunity.

6. Influenza- An annual Flu Vaccination is required. Summer and Fall cohorts will receive notification when the deadline is to turn in documentation for receipt of flu vaccine.

   Spring cohorts are required to turn in documentation with all other immunization information.

Minnesota State Community and Technical College

Exposure and Immunity Requirements Form

Student is to complete this form; return to College Lab Assistant by the assigned deadline.

_____ _____, _____, _____
Student ID # Last Name First name Middle/maiden name

This form must be completely filled out AND Supporting Documentation MUST be attached.

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

2 Step Mantoux Results

Step one

Date read: _____ **Results:** _____

Step two

Date read: _____ **Results:** _____

OR

QuantiFERON tb Gold blood test/ T Spot Blood Test

Date: _____ **Results:** _____

OR

IF a positive Mantoux, QuantiFERON tb Gold Blood Test or T-Spot Blood Test

X-Ray Date: _____ **Results:** _____

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).

Answer the following if history of positive Mantoux test and negative chest x-ray

Do you have any of the following symptoms which may indicate active TB? Check (✓) if applicable

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

If history of positive chest x-ray

Physician documentation of completed therapy is required (please attach).

Exposure / Immunity Requirements Form
Continued, Page 2

Student is to complete this form; return to College Lab Assistant by the assigned deadline.

_____ _____, _____, _____
Student ID # Last Name First name Middle/maiden name

This form must be completely filled out AND Supporting Documentation MUST be attached.

Tdap (diphtheria, tetanus, and acellular-pertussis)

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

Measles, Mumps & Rubella Immunity(MMR)

Student must have ONE of the following.
Check (✓) one

❒ Born before January 1, 1957 OR

❒ Documentation of having received **two doses** of MMR vaccine after 12 months of age
And at least one (1) month apart.
Date of 1st dose: _____ Date of 2nd dose: _____

OR

❒ 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) *

Student must know their chicken pox status.
Check (✓) as appropriate

❒ Have received Varicella vaccine Date of 1st Dose:_____ Date of 2nd Dose: _____

OR

❒ 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).

Select the response which indicates your chosen action.
Check (✓) one

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

❒ I am in PROCESS of completing the Hep B series. Date of 1st dose: _____ Date of 2nd dose: _____

❒ 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

❒ Date of Annual Flu vaccination: _____