STUDENT DATA SHEET
ESCC PRACTICAL
NURSING PROGRAM

Name:____

Student Number: ____

Date of Birth: ____

Mailing Address: ____

____

Phone Numbers: Home ____

Cell ____

E-mail address: ____

Emergency Contact: ____

Emergency Contact Phone: ____

Additional Contact Information: ____

Enterprise State Community College

Substance Abuse Policy
Agreement

In preparation for participation in clinical/laboratory activities of health science programs or other programs/activities requiring drug screening as outlined in the Enterprise State Community College Substance Abuse Policy, I hereby consent to submit to a urinalysis and/or other tests as shall be determined by Enterprise State Community College for the purpose of determining substance use. I agree that specimens for the tests will be collected in accordance with guidelines established in the Mandatory Guidelines for Federal Workplace Drug Testing Programs and as described in the Enterprise State Community College Substance Abuse Policy Guidelines.

I further agree to, and hereby authorize, the release of the results of said tests to the appropriate designee of Enterprise State Community College. All positive results will be reviewed by said College designee and followed by a confidential contact with me.
I understand that positive results indicating the current use of drugs and/or alcohol shall prohibit me from participating in clinical, laboratory, or other activities of health science programs requiring that I be drug free. I also understand that while participating in clinical activities within outside healthcare agencies, I will be subject to thesame rules as the health care employees in said facilities.

I agree to hold harmless Enterprise State Community College and its designee/s Medical Review Officer from any liability arising in whole or in part from the collection of specimens, testing, and use of the results from said tests in connection with excluding me from participation in clinical/laboratory activities.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced by anyone to sign this document. A copy of this signed and dated document will constitute my consent for Enterprise State Community College and its designee/s Medical Review Officer to perform the drug screen and to release the results to Enterprise State Community College.

____
Signature

____
Printed Name Student Number

____
Date

ENTERPRISE STATE COMMUNITY COLLEGE PRACTICAL NURSING
RELEASE OF CLINICAL INFORMATION

I give Enterprise State Community College permission to release copies of my personal clinical/program documentation to clinical agencies as required by contractual agreements. These records will only be released to Human Resources or such centrally governed departments and include, **but are NOT limited to**: immunizations, TB skin tests, titer results, CPR, substance abuse screens, background checks, essential functions/physician's statement, and clinical agency training acknowledgements and verifications, as requested by clinical agencies.

_________________________________ Name (Print)

_________________________________ Department (ESCC Health Program)

_________________________________ Signature

_________________________________ ESCC Student ID #

_________________________________ Date

PRACTICAL NURSING

HEALTH RECORDS POLICY

All students/faculty are required to have a physical examination at their expense. The physical examination / health requirements protect the student/faculty by identifying any potential or real health problems thatmay be exacerbated by the demands of the clinical portion of the program.

Health professions are strenuous, both physically and psychologically. The student/faculty's ability to handle these demands must be established. It is also imperative that students/faculty do not expose clients or agency personnel to communicable disease, or risk their safety due to the inability to handle the physical or psychological stress of client care.

NOTE**:** Updates to health records such as TB or CPR will be required while participating in clinicals. **Any updates will be due at the beginning of the semester in which they expire.** *For example*, aTB skin test is required annually. If it expires in February of the spring semester, the update will be due no laterthan the first week of class, in January.

The following are required:

1. PHYSICAL EXAMINATION – A **physical examination**, completed within the past year, is required for all new students/faculty. The physical must be signed by a licensed physician or nurse practitioner. The examination must be documented on the Program's **Health Record and Essential Functions Form** as required by The Alabama Community College System.

2. IMMUNIZATIONS / TITERS – It is the STUDENT/FACULTY'S RESPONSIBILITY to keep all health records current. **Documentation of any required updates should be submitted to the practical nursing office as soon as possible.** The following are required:

Tetanus (Tdap) Vaccine

Must provide documentation of an ***adult*** **Tdap vaccine** (tetanus, diphtheria, and pertussis). If the documented Tdap vaccine is over ten (10) years old, documentation of a Td (tetanus and diphtheria) or Tdap booster that is less than ten (10) years old is also required. An update is required every ten (10) years.

TB Skin Test

An annual one-step TB Skin Test is required each year and is YOUR RESPONSIBILITY to provide to the practical nursing office when due. Student/Faculty will be unable to attend clinicals if he or she fails to submit to results of annual TB screening.

Documentation of a TB blood test (TB Gold) may be provided in lieu of TB skin test. An annual blood test or one-step TB skin test will be required thereafter.

If you have had a positive TB result, submit proof of that result as well as proof of a clear chest x-ray. Documentation of reason for chest x-ray instead of serum is required.

MMRV Titer

A MMRV - Measles, Mumps, Rubella (German Measles), and Varicella (Chicken Pox) titer is required. If any results are negative or non-immune, the student/faculty must sign the *MMRV Waiver Form* and submit it with the negative or non-immune results. The student is advised to consult with a physician regarding precautions to prevent infection. **Vaccination records will not be accepted in place of titer results.**

Hepatitis B

A Hepatitis B titer is required. If the results are negative or non-immune, the student/faculty must sign the *Hepatitis B Waiver Form* to be submitted with these results. The student/faculty is advised to consult with a physician regarding precautions to prevent infection. Results must be within the past twenty (20) years.
Vaccination records will not be accepted in place of titer results.

Enterprise State Community College – Practical Nursing Program

STUDENT INFORMATION / CHECKLIST

Turn in all health record documentation to Nursing Program Personnel by the required deadline.

Faculty Name:____Faculty ID Number: ____________________________

ITEM	DOCUMENTATION REQUIRED	☑
Physician's Statement	The *Health Records Form* must be signed by the student/faculty and signed by a **physician, physician's assistant, or a nurse practitioner.** ***Attach completed form.***	
Health Record Form	The *Health Record Form* must be completed and signed by a **physician, physician's assistant, or a nurse practitioner.** ***Attach completed form.***	
Tetanus (Tdap) Vaccine	Documentation of an ***adult*** Tdap vaccine. Any Tdap older than ten (10) years must also be followed by documentation of a Tetanus booster (Td or Tdap) that is less than ten (10) years old. ***Attach medical documentation.***	
PPD or Tuberculosis (TB Skin Test)	Documentation of a TB Skin Test. TB skin tests are good for a period of one (1) year from the administration date. An annual one-step TB skintest will be required thereafter. ***Attach medical documentation.*** **OR** Documentation of a TB blood test (TB Gold). An annual blood test or one-step TB Skin Test will be required thereafter. **Attach medical documentation.** **OR** Documentation of a clear **chest x-ray** will be accepted for those who are unable to receive the TB skin test due to a positive TB result or previous BCG vaccination. Completion of an annual *Tuberculosis Questionnaire* will also be required. **Attach medical documentation.**	
MMRV Titers	Documentation of **titer** results for MMRV – Measles (Rubeola), Mumps, Rubella (German Measles), and Varicella (Chicken Pox). If results are non-immune (negative) or equivocal, the student/faculty is instructed to seek the advice of a medical provider for recommended follow-up and must sign a *Measles, Mumps, Rubella, Varicella Release / Waiver Form*. ***Attach lab data report.***	
Hepatitis B Titer	Documentation of **titer** results for Hepatitis B. Results must be within the past twenty (20) years. If results are non-immune (negative), the student/faculty is instructed to seek the advice of a medical provider for recommended follow-up and must sign a *Hepatitis B Vaccination Release / Waiver Form*. **Attach lab data report.**	
CPR	Documentation of current CPR certification by the American Heart Association Basic Life Support (BLS) for Health Care Providers (CPR/AED) or American Red Cross CPR for Professional Rescuer. **Attach a copy of card / certificate**	
Release Form	Read and sign the *Release of Clinical Information* form. **Attach completed form.**	

IMPORTANT: All documentation must be legible. It is a student/faculty's responsibility to maintain a personal file with all health records.

It is the student/faculty's responsibility to also retain a copy of these records and to take them to clinicals.

Enterprise State Community College – Practical Nursing Program
HEALTH RECORD FORM

Name:____**Employee ID #:**______________________
(Please Print)
Address:____**Contact Number:**____________________

Emergency Contact Person:____**Contact Number:**____________________

INSTRUCTIONS: A physician, nurse practitioner, or physician's assistant must complete and sign this form. Attach copies of lab results documenting Tdap vaccination (and booster if applicable), TB skin test, or TB blood test and/or chest x-ray, and MMRV and Hepatitis B titer results when submitting this form to Practical Nursing Program personnel or Program Secretary. If TB chest x-ray is required, documentation of reason for chest x-ray instead of serum is required.

Requirements	
Tetanus Vaccine (tetanus, diphtheria, pertussis) *All students **must** have a documented Tdap vaccine.*	**Date Administered ------------------**
Td or Tdap Booster *Only applicable if above Tdap vaccine is older than ten (10) years. Adult Tdap must be followed by Td booster every ten years thereafter.*	**Date Administered ------------------** **OR** **Not Applicable**_________(physician's initials)
MMRV Titers ***Titer results are required***. Vaccination records will not be accepted in place of titer results	**Date(s) Drawn / Results:** **Measles** ___-____-___ / ☐ Immune ☐ Not Immune ☐ Equivocal **Mumps** ___-____-___ / ☐ Immune ☐ Not Immune ☐ Equivocal **Rubella** _____-_____-_____ / ☐ Immune ☐ Not Immune ☐ Equivocal **Varicella** _____-_____-_____ / ☐ Immune ☐ Not Immune ☐ Equivocal
Hepatitis B Titer ***Titer results are required***. *Vaccination records* will not *be accepted in place of titer results.*	**Date Drawn / Results:** _____-_____-_____/ ☐ Immune ☐ Not Immune
TB Skin Testor **Chest X-ray** *A one-step TB update will be required thereafter.* *A TB blood test may be used in place of a two-step TB skin test.* ***Those who have tested positive for TB or who are unable to receive the TB skin test must submit narrative documentation of a clear chest x-ray. Documentation of reason for chest x-ray instead of serum is required.***	Lot #__________Manuf.___________Exp. Date ___________ Time Applied__________Reader Signature Date Administered:___________-______-______Date Read: ---------------------_____ Result:_______mm of induration Interpretation: ☐ Positive ☐ Negative **OR**______________________________________ **TB Blood Test – Date Drawn / Results** **_____-______-_____/ ☐ Postitive ☐ Negative Type of Test:** ______________________ **OR**______________________________________ **Chest X-Ray** Date of CXR:______-______-_____/ Result: ☐ Normal ☐ Abnormal

Healthcare Provider Signature Required: I have reviewed this immunization status and have maderecommendations regarding any follow-up related to safe practice as a health care provider.

____
Physician, PA, or NP (Signature) Date Contact Number

____
Physician, PA, or NP (Printed) Address

ESSENTIAL FUNCTIONS FORM
Enterprise State Community
College

Practical Nursing Program

The Alabama Community College System endorses the Americans' with Disabilities Act. In accordance with College policy, when requested, reasonable accommodations may be provided for individuals with disabilities.

Physical, cognitive, psychomotor, affective and social abilities are required in unique combinations to provide safe and effective nursing care. The student/faculty must be able to meet the essential functions with or without reasonable accommodations throughout the program of learning. The Practical Nursing Program and/or its affiliated clinical agencies may identify additional essential functions.

In order to be function safely in the Practical Nursing Program one must possess a functional level of ability to perform the duties required of a nurse.

The essential functions delineated are those deemed necessary for the Practical Nursing Program. No representation regarding industrial standards is implied. Similarly, any reasonable accommodations provided will be determined and applied to the respective Practical Nursing Program and may vary from reasonable accommodations made by healthcare employers.

The following essential functions delineated are necessary for the provision of safe and effective nursing care.

Nursing Program Essential Functions

The Alabama College System endorses the Americans' with Disabilities Act in accordance with Enterprise State Community College Policy, when requested, reasonable accommodations may be provided for individuals with disabilities. The essential functions below are necessary for the provision of safe and effective nursing care. The essential functions include but are not limited to the ability to:

1) **Sensory Perception**
    a) Visual (with or without corrective lenses)
        i) Observe and discern subtle changes in physical conditions and the environment
        ii) Visualize different color spectrums and color changes
        iii) Read fine print in varying levels of light
        iv) Read for prolonged periods of time
        v) Read cursive writing
        vi) Read at varying distances
        vii) Read data/information displayed on monitors/equipment
    b) Auditory
        i) Interpret monitoring devices
        ii) Distinguish muffled sounds heard through a stethoscope
        iii) Hear and discriminate high and low frequency sounds produced by the body and the environment
        iv) Effectively hear to communicate with others
    c) Tactile
        i) Discern tremors, vibrations, pulses, textures, temperature,shapes, size, location and other physical characteristics
    d) Olfactory
        i) Detect body odors and odors in the environment
2) **Communication/ Interpersonal Relationships**
    a) Verbally and in writing, engage in a two-way communication and interact effectively with others, from a variety of social, emotional,cultural and intellectual backgrounds
    b) Work effectively in groups
    c) Work effectively independently
    d) Discern and interpret nonverbal communication
    e) Express one's ideas and feelings clearly
    f) Communicate with others accurately in a timely manner
    g) Obtain communications from a computer

3) **Cognitive/Critical Thinking**
    a) Effectively read, write and comprehend the English language
    b) Consistently and dependably engage in the process of critical thinking in order to formulate and implement safe and ethical nursing decisions in a variety of health care settings
    c) Demonstrate satisfactory performance on written examinationsincluding mathematical computations without a calculator
    d) Satisfactorily achieve the program objectives

4) **Motor Function**

a) Handle small delicate equipment/objects without extraneousmovement, contamination or destruction
b) Move, position, turn, transfer, assist with lifting or lift and carryclients without injury to clients, self or others
c) Maintain balance from any position
d) Stand on both legs
e) Coordinate hand/eye movements
f) Push/pull heavy objects without injury to client, self or others
g) Stand, bend, walk and/or sit for 6-12 hours in a clinical setting performing physical activities requiring energy without jeopardizing the safety of the client, self or others
h) Walk without a cane, walker or crutches
i) Function with hands free for nursing care and transporting items
j) Transport self and client without the use of electrical devices
k) Flex, abduct and rotate all joints freely
l) Respond rapidly to emergency situations
m) Maneuver in small areas
n) Perform daily care functions for the client
o) Coordinate fine and gross motor hand movements to providesafe effective nursing care
p) Calibrate/use equipment
q) Execute movement required to provide nursing care in allhealth care settings
r) Perform CPR and physical assessment
s) Operate a computer

5) **Professional Behavior**

a) Convey caring, respect, sensitivity, tact, compassion, empathy,tolerance and a healthy attitude toward others
b) Demonstrate a mentally healthy attitude that is ageappropriate in relationship to the client
c) Handle multiple tasks concurrently
d) Perform safe, effective nursing care for clients in a caringcontext
e) Understand and follow the policies and procedures of the College and clinical agencies
f) Understand the consequences of violating the student code ofconduct
g) Understand that posing a direct threat to others isunacceptable and subjects one to discipline
h) Meet qualifications for licensure by examination as stipulatedby the Alabama Board of Nursing
i) Not to pose a threat to self or others
j) Function effectively in situations of uncertainty and stressinherent in providing nursing care
k) Adapt to changing environments and situations
l) Remain free of chemical dependency
m) Report promptly to clinical and remain for 6-12 hours on theclinical unit
n) Provide nursing care in an appropriate time frame
o) Accepts responsibility, accountability, and ownership of one’s actions
p) Seek supervision/consultation in a timely manner
q) Examine and modify one’s own behavior when it interferes with nursing care or learning.

Enterprise State Community College
Practical Nursing Program

HEALTH RECORD AND STATEMENT OF ESSENTIAL FUNCTIONS SIGNATURE PAGE

STUDENT STATEMENT

I have reviewed the Essential Functions I certify that to the best of my knowledge, I have the ability to perform these functions with or without reasonable accommodations.

____
Student Signature   Date

____
Student's Name (Printed)

PHYSICIAN STATEMENT

Based upon my assessment and evaluation, this person's mental and physical health

is____________ is not ____________

sufficient to perform the classroom, laboratory, and clinical duties of a practical nursing faculty.

If person *<u>is not</u>* *mentally or physically sufficient to perform, please explain. (Attach additional sheet if necessary)*

____
Physician, PA, or Nurse Practitioner (Signature)   Date   Contact Number

____
Physician, PA, or Nurse Practitioner (Printed)   Address

Effective 07/2023

ENTERPRISE STATE COMMUNITY COLLEGE

HEALTH SCIENCES 2023-2024

Flu Vaccine Info-- Students and Instructors

Print Name: ____

In order to document clinical attendance during the reported flu season of **October 1, 2023 – March 31, 2024**, Health Sciences students are required to respond to the following items.

Please note: Healthcare facilities may have requirements specific to their implementation of guidelines. For example, policy may prohibit patient care inside their facility for those who have not taken a current flu vaccine, or require wearing of a mask for persons granted exceptions.

Please check the following items that apply:

Are you an employee of a healthcare facility?

_______ **No**

_______ **Yes If yes, which facility?** ____

_______ **Yes,** I have received the flu vaccine. **Documentation required.**

_______ **No**, I do not wish to have the flu vaccine given to me. **If assigned to a facility which requires vaccination of all caregivers, you may not be allowed to complete clinical unless granted an exception. If granted an exception, you may be required to wear a mask during your clinical rotation (You may take the mask off while eating or going to the bathroom)**

_______ I am **not able** to receive the flu vaccine due to medical reasons:

- _______Severe allergic reaction to eggs or other components of the flu vaccine
- _______A history of Guillain-Barre syndrome within six weeks after a previous flu vaccination
- ______Other:____

I **do not wish** to receive the flu vaccines for the following reason:

Please check all that apply:

______Fear of side effects ______Fear of getting the flu_______Religious objection

______Fear of injections ______Just do not want to ______Other reasons

Aggregate data will be reported to the Centers for Medicare and Medicaid Services (CMS) & the CDC.

Signature:____Date: ____________

ENTERPRISE STATE COMMUNITY COLLEGE
FLU Vaccination Receipt
2023-2024

Name: ____________________________________
(Please Print)

Student/Instructor ID#:________________________

Vaccination Date: ____________________________

Lot #:___________________Expiration date:_________________Site: L R Deltoid

Office Providing Vaccine: ____

Person Administering Flu Vaccination: ____
(Please Print)

____
(Signature)

ENTERPRISE STATE COMMUNITY COLLEGE

HEALTH SCIENCES 2023-2024

Covid-19 Vaccine Info-- Students and Instructors

Print Name**:** ____

In order to document clinical attendance during the 2023-24 academic year, practical nursing students are required to respond to the following items.

Please note: Healthcare facilities may have requirements specific to their implementation of guidelines. For example, policy may prohibit patient care inside their facility for those who have not taken a current Covid-19 vaccine, and may require wearing of a masks for all students regardless of vaccination status.

Please check the following items that apply:

Are you an employee of a healthcare facility? ______ **No** ______ **Yes If yes, which facility?** ____________________________________
______ **Yes,** I have received the Covid-19 vaccine. **Attach required documentation.** ______ **No**, I do not wish to have the Covid-19 vaccine given to me. **If assigned to a facility which requires vaccination of all caregivers, you may not be allowed to complete clinical unless granted an exception. If granted an exception, you may be required to wear a mask during your clinical rotation (You may take the mask off while eating or going to the bathroom)**
______ I am **not able** to receive the Covid-19 vaccine due to medical reasons: ______Severe allergic reaction to components of the vaccine ______Other:____________________________________
I **do not wish** to receive the Covid-19 vaccine for the following reason: Please check all that apply: _____Fear of side effects _____Fear of getting Covid-19____Religious objection _____Fear of injections _____Just do not want to _____Other reasons

Aggregate data will be reported to the Centers for Medicare and Medicaid Services (CMS) & the CDC.

Signature:____Date: ____________