Policy and Procedure Manual
Student Health Clearance

POLICY: It is the policy of The Vocational Nursing Institute, Inc. upon admission to the Vocational Nursing (VN) Program and/or Nurse Aide (NA) Program that each student provides evidence of immunity and health status. Each student is required to show proof from their primary care physician that they are cleared to work with patients in a nursing student/nursing assistant capacity. All health information is kept confidential per HIPAA regulations. (see HIPAA policy and procedure manual).

Prior to the first day of class each student must furnish the school with the following documents:

1) VN/NA **Annual History and Physical** – letter from the physician stating the student passed a physical. If the student is pregnant, or becomes pregnant or ill during the semester, then a release must be obtained from the physician releasing the school of all liability and that the student may attend school including lifting patients and caring for sick patients while pregnant.

2) VN/NA Hepatitis **B Series (HBV) (or waived form)** –copy of 3 shot series or waived form

3) VN/NA **TB test or chest x ray within the past 12 months** – Provide proof of TB Testing date. See infection control policies

5) VN/NA **Measles, Mumps, and Rubella and/or rubella titer** – need proof of positive titer (lab test) for Measles, Mumps, and Rubella initialed by the health care provider for the student.

6) VN/NA **Varicella (chicken pox)** – titer values initialed by the health care provider are acceptable (lab report) if original evidence of immunity is not available.

7) VN/NA **Tetanus and Diphtheria (Td or TdAP)** – must present evidence of exact date of vaccination within the last 10 years. If no documentation is available, then it must be done.

The school will offer and include AHA CPR to each student prior to their start date.

The school recommends that you take an influenza vaccine including H1N1.

PURPOSE: The nursing and nursing assistant students will have learning experiences that involve patient contact. The students will be at risk for both exposure and transmission of communicable diseases and blood borne pathogens. Therefore, the school policy is to decrease the health risks to patients and students alike and to protect the students and patients as much as possible by following the school's policies relating to infection control, OSHA, and the CDC (Centers for Disease Control).

Note: All clinical sites the school is working with have requirements for health clearance that the school must adhere to.. It is mandatory that all health clearance documents be submitted within 5 days of starting the program and prior to the 1st day of clinical learning experiences. If not submitted, the student risks not participating in clinical rotations. All Clinical hours must be completed to graduate course.

If a student becomes ill or is hospitalized during the school year and becomes contagious or unable to perform his/her nursing student duties; an updated health clearance must be submitted from the health

care provider who was providing treatment to the student prior to the student returning to the clinical environment. The statement from the health care provider must be dated and state the student is able to return to their nursing student responsibilities as well are free from any health impairment which is a potential risk for them or for the patients. Once a student is cleared by the Senior Clinical Instructor, the student must see the School Director to coordinate clinical make-up time. Make up sessions for clinical rotations are very difficult to arrange especially with the hospital systems. The school does not guarantee clinical rotation make up, which can delay graduation.

Some of the clinical sites may require additional information such as background checks, state child abuse registry checks, drug testing, as applicable. We will notify you if this is the case.

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Nursing Student & Nurse Aide Student

Student Name: _____

☐	Proof of Negative TB test or chest x-ray
☐	CPR card
☐	Annual History and Physical Documentation
☐	Vaccination for Measles, Mumps, Rubella Documentation
☐	Rubella Titer as applicable
☐	Tetanus (Td or TdAP) with exact date in last 10 years Documentation
☐	Varicella Titer Documentation
☐	Hepatitis B evidence of 3 shot series or waived form
☐	Pregnancy clearance as applicable
☐	Flu vaccine Documentation (not mandatory)
☐	Authorization of student to share records with clinical sites Documentation

Students should submit this information to Kim Kelly RN BSN LNC (School Director) or designee no later than the fifth day of class. We encourage you to submit this information as soon as possible after being notified of your acceptance into the program.

_____

Completed by (First Name / Last Name) (Title) (date)

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IMMUNIZATION DOCUMENTATION FORM

I _____hereby release the following health information
Print First, Middle, Last Name

to The Vocational Nursing Institute, Inc. (VNI). I understand that additional information may be required and authorize VNI to release my health clearance information. All other documents associated maybe required for my participation as a nursing student with clinical experience.

_____
Student Signature Date

PLEASE MAKE SURE ALL LAB REPORTS ARE ATTACHED AND INITIALED BY THE NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR PHYSICIAN.

PRIOR VACCINATION HISTORY MUST BE ATTACHED FOR NEGATIVE TITERS.

Type of Immunization	Date Titer Drawn	Numerical Value	Pos. / Neg	Revaccination Date as applicable
Measles				
Mumps				
Rubella				
Varicella				
Hepatitis B				
Diphtheria/ Tetanus Toxoid (Td or TdAP) in last 10 years				

_____
Signature of Certified Nurse Practitioner/Physician Assistant/Physician Title Date

_____
Print Name Certified NP/PA/Physician

Physician Address:

_____
Number Street City State Zip

STUDENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND EDUCATION RECORDS TO CLINICAL ROTATION SITES

I understand that copies of my health records, performance records, status in the program, criminal history, competency and skills level(s), initiative and professional behavior, interactions with teachers, students, and patients, may be shared by the faculty of The Vocational Nursing Institute, Inc. and the staff of the rotation sites as applicable.

I _____ give The Vocational Nursing Institute, Inc.
Student name (first, middle, last)

program faculty and staff permission to disclose my relevant education and/or health records to

the clinical rotation sites for the year _____, only to the extent necessary for
i.e. 2011-2012

my progression in and completion of my program.

_____

Student Signature Printed Name Date

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HEPATITIS B VACCINE CONSENT FORM

Hepatitis B infection is caused by the Hepatitis B virus, which causes death in 1% to 2% of patients. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. The healthcare provider is at an increased risk for acquiring this infection. Hepatitis B vaccine (recombinant) is available and requires three injections for adequate response, although some persons may not develop immunity even after three doses. The duration of immunity is unknown at this time. The vaccine has been tested extensively for safety and efficiency in large-scale clinical trials with human subjects.

Engirex-B is a non-infectious recombinant DNA Hepatitis B vaccine. It contains purified surface antigen of the virus obtained by culturing a genetically engineered yeast cell, which carries the surface antigen gene of the Hepatitis B virus. The product contains no more than a 5% yeast protein. The vaccine side effects are very low. Tenderness and redness of the injection site and low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. I should not take this vaccine if pregnant or nursing because effects at this time are unknown. I further understand that I should not take this vaccine if active infection is present, an allergy to this compound is known, or if hypersensitive to yeast.

****

I have read the above statement, and have had the opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccine. I understand I must have three doses of the vaccine to confer immunity, however as with all medical treatment there is no guarantee that I will become immune or that I will not experience side effects from the vaccine.

_____

PRINTED NAME OF STUDENT SIGNATURE OF STUDENT

I REALIZE IT IS MY RESPONSIBILITY TO RETURN IN ONE (1) AND SIX (6) MONTHS AFTER MY FIRST DOSE TO COMPLETE MY VACCINATION SERIES.

DATE VACCINATED	LOT #	SITE	INITIALS	NEXT DOSE DUE WEEK OF	SIGNATURE OF RECIPIENT
1.					
2.					
3.					

HEPATITIS B VACCINE REFUSAL FORM

Hepatitis B infection is caused by the Hepatitis B virus, which causes death in 1% to 2% of patients. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. The healthcare provider is at an increased risk for acquiring this infection.

Hepatitis B vaccine (recombinant) is available and requires three injections for adequate response, although some persons may not develop immunity even after three doses. The duration of immunity is unknown at this time. The vaccine has been tested extensively for safety and efficiency in large-scale clinical trials with human subjects.

Engirex-B is a non-infectious recombinant DNA Hepatitis B vaccine. It contains purified surface antigen of the virus obtained by culturing a genetically engineered yeast cell, which carries the surface antigen gene of the Hepatitis B virus. The product contains no more than a 5% yeast protein.

The vaccine side effects are very low. Tenderness and redness of the injection site and low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. I should not take this vaccine if pregnant or nursing because effects at this time are unknown. I further understand that I should not take this vaccine if active infection is present, an allergy to this compound is known, or if hypersensitive to yeast.

I have had the opportunity to ask questions about the risks and benefits of the vaccine.

I have read the above statement, however; I decline the Hepatitis vaccination at this time. I understand that by declining this vaccine I continue to be at increased risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or body fluids and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series.

q I have previously received a complete series of Hepatitis B vaccine.

DATES: _____ _____ _____

_____ _____
PRINTED NAME OFSTUDENT SIGNATURE OF STUDENT

_____ _____
DATE SIGNED