ENTERPRISE STATE
COMMUNITY COLLEGE

STUDENT DATA SHEET
ESCC PRACTICAL
NURSING PROGRAM

Student 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 further understand that clinical/laboratory components of courses within health programs are required curriculum components and that an inability to attend said components may prevent or delay my program completion. I also understand that while participating in clinical activities within outside healthcare agencies, I will be subject to the same 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

Background Screening Consent and Release Form

I have received and carefully read the Background Screening Policy for Students in the Health Sciences. I understand that compliance with the background screening policy is a requirement to complete my admission to and/or maintain enrollment in a health care program at Enterprise State Community College.

By signing this document, I am indicating that I have read and understand Enterprise State Community College's Background Screening Policy for Students in the Health Sciences. My signature also indicates my agreement to complete the requirement and to submit required information to the approved screening vendor. I understand that my enrollment in health program courses is conditional to the provision of negative findings or facility approval upon circumstantial review. In the event of positive findings on my background screen and follow-up denial of access to records, declares me ineligible to continue in clinical learning experiences, and further attendance in health program courses will not be allowed. I will be offered the opportunity to withdraw from all courses in my health program for which I am enrolled. My failure to withdraw as directed will result in the assignment of the appropriate course grade, WF.

A copy of this signed and dated document will constitute my consent to abide by the College's Background Screening Policy. Upon submission of my personal information to the approved screening vendor, I also consent to approve the release of the original screening results to the approved College designee. A copy of this signed and dated document, along with approval during the information submission process, will constitute my consent for the College to release the results of my background screen to the clinical affiliate(s)' specifically designated person(s). I agree to hold harmless the College and its officers, agents, and employees from and against any harm, claim, suit, or cause of action, which may occur as a direct or indirect result of the background screen or release of the results to the College and/or the clinical affiliates. I understand that should any legal action be taken as a result of the background screen, that confidentiality can no longer be maintained.

I agree to abide by the aforementioned policy. 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 into signing this document. I hereby acknowledge that I will authorize the College's contracted agents to procure a background screen on me. I further understand this signed consent hereby authorizes the College's contracted agents to conduct necessary and/or periodic background screens and/or updates as required by contractual agreements with clinical affiliates.

_____	_____
Student Signature	Witness Signature
_____	_____
Student's Printed Name	Witness' Printed Name
_____	_____
Date	Date

Enterprise State Community College
Practical Nursing Program

Liability Release Form

I,_____, hereby acknowledge that I fully understand the contents of this release and that I am signing it voluntarily.

As a student of the Practical Nursing Program at Enterprise State Community College, I am aware of the risk of personal injury or illness which is inherent in my participating in classroom, laboratory, clinical and preceptorship activities. I understand that medical insurance and responsibility for payment of medical bills incurred during the program are my responsibility. I further understand that I am responsible for all vaccinations, including hepatitis B, that are required for program admission.

Upon full awareness and consideration of the risks which I might assume in participating in classroom, laboratory, clinical or preceptorship activities, I hereby agree to release Enterprise State Community College and its instructors, officials, agents, representatives, clinical sites, and employees from any liability for any type of illness or injury which is incurred to me during my participation in the program. This release will remain in effect for the duration of my enrollment in the Practical Nursing Program.

_____
Student Signature / Date

_____
Witness Signature / 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.

_____ _____
Student Name (Print) Department (ESCC Health Program)

_____ _____
Signature ESCC Student ID #

_____
Date

ENTERPRISE STATE COMMUNITY COLLEGE
PRACTICAL NURSING

WAIVER OF RESPONSIBILITY

I,_____(print name), a student in the ***Practical Nursing Program*** at Enterprise State Community College, accept all responsibilities for accident/illness/injury sustained in or related to the performance of normal class/lab/clinical activities. Therefore, I hold the College/clinical agency harmless should accident/illness/injury occur.

_____ _____
Student Signature Date

_____
Student ID#

PRACTICAL NURSING PROGRAM
HEALTH INSURANCE FORM

It is recommended that all students in the Practical Nursing Program have health insurance. You MUST complete the applicable portion of this form prior to any clinical or learning lab experience. If you do not have health insurance, you are required to sign a waiver that will remain in the Practical Nursing Program files.

Name of Insurance Company _____

_____
Student's Signature

_____
Date

WAIVER:

I,_____, have been informed and understand the importance
(Name of Student)
of obtaining health insurance. I am currently not covered by personal health insurance and elect not to obtain any health insurance at this time. I understand that it is my responsibility to pay for all medical expenses that result from illness or injury that may occur while I am a student in the Practical Nursing Program.

I release Enterprise State Community College and/or its agents, and any and all affiliate clinical facilities and/or their agents from any liability related to injuries or illness received while a student in the Practical Nursing Program.

_____
Student's Signature

_____
Date

Include a copy of valid Driver's License & Health Insurance

(Copiers available in Resource Center)

PRACTICAL NURSING

HEALTH RECORDS POLICY

Validation and documentation of required health records must be received by all students enrolled in a health program. **Students who fail to submit required records will not be allowed to continue in the program.** *If you have questions concerning this process, contact Amy Phillips at 334-347-2623 extension 2267.*

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

Health professions are strenuous, both physically and psychologically. The student's ability to handle these demands must be established. It is also imperative that students 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 may be required while a student is enrolled in the program. **Any updates will be due at the beginning of the semester in which they expire.** *For example*, a TB 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 for **ALL** students:

1. PHYSICAL EXAMINATION – A **physical examination**, completed within the past year, is required for all new students. 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. New students and any student returning to an allied health program after an absence of one (1) year must submit current completed health forms.

2. IMMUNIZATIONS / TITERS – It is the STUDENT'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

   Students entering an allied health program 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

   A **two-step** TB Skin Test is required at the beginning of the program. This consists of one test followed by a second test 7-21 days later. The results cannot be more than four (4) weeks apart.

   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.

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

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 to enter practical nursing program. If any results are negative or non-immune, the student 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 to enter the practical nursing program. If the results are negative or non-immune, the student must sign the *Hepatitis B Waiver Form* to be submitted with these results. The student 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.

3. CONTINUING HEALTH STATUS – It is a STUDENT'S RESPONSIBILITY to notify the program faculty of any changes in his/her health status, i.e. pregnancy, surgery, injuries, etc. Additional examinations from a health care provider, with documentation of results, may be required by an instructor for any changes in a student's health status.

4. PROFESSIONAL LIABILITY INSURANCE – Students in a practical nursing program are required to purchase professional liability insurance (malpractice insurance) through the College, each semester they enroll in a nursing course. This fee is added to your course registration and is to be paid at registration each applicable semester.

5. HEALTH INSURANCE – Enterprise State Community College and the practical nursing programs do not provide health insurance coverage for students. Students are responsible for costs incurred as a result of an accident/injury in the clinical or college laboratory. This may include follow-up testing and/or treatmentmandated by the program/clinical agency. Students are not entitled to any Workmen's Compensation benefits from agencies. Health insurance coverage is strongly recommended.

Enterprise State Community College – Practical Nursing Program

STUDENT INFORMATION / CHECKLIST

Before beginning any Practical Nursing Program course, you must submit proof of the following items. NO exceptions can or will be made regarding submission of documentation by a medical professional. Turn in all health record documentation to Nursing Program Personnel by the required deadline.

Student Name:_____ Student ID Number: _____

ITEM	DOCUMENTATION REQUIRED	☑
Essential Functions / Physician's Statement	The *Health Records and Statement of Essential Function Form* must be signed by the student 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 *two-step* TB skin test, consisting of one test followed by a *second test 7-21 days later*. *The results cannot be more than four (4) weeks apart*. TB skin tests are good for a period of one (1) year from the administration date. An annual one-step TB skin test 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 students 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 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 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. Copies will not be made for you by Program personnel. It is a student's responsibility to maintain a personal file with all health records. Once submitted to the Practical Nursing Program Office, no records will be released back to students. There is a student copier available in the Learning Resource Center.

It is the student'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:_____ **Student 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
2-step TB Skin Test **or Chest X-ray** *Results from the two-step TB skin tests **cannot be more than four (4) weeks apart**. Results are valid for one year. 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.* ***Students 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.***	**1st Step** Lot #_____Manuf._____Exp. Date _____ Time Applied_____Reader Signature Date Administered:_____-_____-_____Date Read: ---------- _____ Result:_____mm of induration Interpretation: □ Positive □ Negative **2nd Step** 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** _____-_____-_____/ □ **Positive** □ **Negative Type of Test:** _____ **OR**_____ **Chest X-Ray** Date of CXR:_____-_____-_____/ Result: □ Normal □ Abnormal

Healthcare Provider Signature Required: I have reviewed this student's immunization status and have made recommendations 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 applicant/student must be able to meet the essential functions with or without reasonable accommodations throughout the program of learning. Admission, progression and graduation are contingent upon one's ability to demonstrate the essential functions delineated for the Practical Nursing Program with or without reasonable accommodations. The Practical Nursing Program and/or its affiliated clinical agencies may identify additional essential functions. The Practical Nursing Program reserves the right to amend the essential functions as deemed necessary.

In order to be admitted and to progress in the Practical Nursing Program one must possess a functional level of ability to perform the duties required of a practical nurse. Admission or progression may be denied if a student is unable to demonstrate the essential functions with or without reasonable accommodations.

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 Practical Nursing Program admission, progression and graduation and 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 nursing program admission, progression and graduation and 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 examinations including mathematical computations without a calculator
   d) Satisfactorily achieve the program objectives

4) **Motor Function**
   a) Handle small delicate equipment/objects without extraneous movement, contamination or destruction
   b) Move, position, turn, transfer, assist with lifting or lift and carry clients 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 provide safe effective nursing care
   p) Calibrate/use equipment
   q) Execute movement required to provide nursing care in all health 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 age appropriate in relationship to the client
   c) Handle multiple tasks concurrently
   d) Perform safe, effective nursing care for clients in a caring context
   e) Understand and follow the policies and procedures of the College and clinical agencies
   f) Understand the consequences of violating the student code of conduct
   g) Understand that posing a direct threat to others is unacceptable and subjects one to discipline
   h) Meet qualifications for licensure by examination as stipulated by the Alabama Board of Nursing
   i) Not to pose a threat to self or others
   j) Function effectively in situations of uncertainty and stress inherent 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 the clinical 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 for this program and I certify that to the best of my knowledge, I have the ability to perform these functions. I understand that a further evaluation of my abilities may be required and conducted by the Practical Nursing faculty, if deemed necessary, to evaluate my ability prior to admission to the program and for retention and progression through the program.

_____

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 student.

If person is not 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 01/2022

ENTERPRISE STATE COMMUNITY COLLEGE

HEALTH SCIENCES 2021-2022

Flu Vaccine Info-- Students and Instructors

Print Name**:** _____

In order to document clinical attendance during the reported flu season of **October 1, 2021 – March 31, 2022**, 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 by the facility, you will 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

2021-2022

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
2021-2022

Covid-19 Vaccine Info-- Students and Instructors

Print Name**:** _____

In order to document clinical attendance during the 2021-22 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 by the facility, you will be required to wear amask 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: _____