All students enrolled in health related courses who have or will have any direct client contact must show proof of the following immunizations prior to starting the clinical component of their course.

### MMR (Measles/Mumps/Rubella):
Health Care Provider **signature** verifying record of date of illness or **two (2) DOSES** on or after first birthday, and at least 30 days apart or a laboratory report of immune serum antibody **TITER**. (Attach). If given separately, attach all appropriate paperwork.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of Illness</th>
<th>Date of 1st and 2nd Immunization</th>
<th>Date of TITER</th>
<th>Immune/not immune</th>
<th>Health Care Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Chicken pox:
Health Care Provider **signature** verifying record of date of illness or **varicella vaccine** or a laboratory report of immune serum antibody **TITER**. (Attach)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of Illness</th>
<th>Date of Immunization</th>
<th>Date TITER</th>
<th>Immune/not immune</th>
<th>Health Care Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
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</tr>
</tbody>
</table>

### TB (PPD):
PPD Skin Test is required upon admission and yearly thereafter. Students with a history of a **positive** PPD test should obtain a chest X-ray. (Attach radiology report)

<table>
<thead>
<tr>
<th>Date PPD Skin Test</th>
<th>Date Test Read</th>
<th>Reaction</th>
<th>Date of Chest x-ray</th>
<th>X-ray attached</th>
<th>Other Treatment</th>
<th>Health Care Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Year</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Diphtheria-Tetanus:
All students must submit proof of a booster shot within the past ten years. If Td or D/T is more than two (2) years old, must show evidence of receiving **DTaP** (diphtheria, tetanus toxoids and acellular pertussis vaccine)

<table>
<thead>
<tr>
<th>Date of Booster Vaccine</th>
<th>Health Care Provider signature</th>
</tr>
</thead>
</table>

### Hepatitis B:
Required to begin series before entering. Verification must be submitted when series completed. A Health Care Provider’s **signature** is required to verify dates or exemption from series or submit **TITER RESULTS**.

<table>
<thead>
<tr>
<th>Date of Immunization</th>
<th>Health Care Provider signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B Vaccination #1</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccination #2</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccination #3</td>
<td></td>
</tr>
<tr>
<td>Date of TITER Immune/not Immune</td>
<td></td>
</tr>
</tbody>
</table>

---

**Health Care Provider Signature***

*Validates all information above

**Pregnancy is a contraindication to many vaccines. Seek your physician’s advice if you are pregnant. Women should be counseled not to become pregnant for three months after vaccination or until properly advised by a physician.**
LONE STAR COLLEGE-TOMBALL

Nursing Immunization Requirements

**Tuberculosis Screening**
- Must be Mantoux PPD administered intradermally
- Must be read within 72 hours at site where it was administered
- For a positive PPD - size of induration must be documented in mm. and must have doctor's statement of treatment plan attached.
- Students with a history of positive PPD must submit chest x-ray results less than one (1) year old and show proof of treatment
- All foreign born students who have received the BCG vaccine are not exempt from the PPD screening test
- Documentation of a PPD taken within the past year will be accepted; however, it must be repeated after the one (1) year deadline - example: PPD given January 2002 - next screening shot due on January 2003

**Measle, Mumps and Rubella**
Handled in one of three ways:
- Doctor verifies proof of the disease
- Titer blood level showing immunity
- Proof of vaccination (MMR)

Student **born in or after 1957** must show proof of two (2) measles vaccinations (or doctor verified proof of disease or titer level). These are scheduled one month apart. Measles vaccinations, also known as Rubella.

Student born **before 1957** must present proof of only one (1) vaccination (or doctor verified proof of disease or titer level).

**Td or D/T Booster (Diptheria/Tetanus)**
- Must be less than 10 years old
- If Td or D/T more than two (2) years old, must show evidence of receiving Tdap, which is tetanus toxoids, diphtheria, and acellular pertussis vaccine.
- CDC now recommends that healthcare workers receive Tdap to prevent all three diseases.

**Hepatitis B**
You must bring proof of completion of the series of three (3) injections or a titer blood level showing immunity prior to orientation deadline.
Regular injection schedule (0, 1, 6 months) or accelerated schedule (0, 1, 2 months, booster in a year) is acceptable.
(Lone Star College-North Harris Hepatitis B Vaccination Clinic Information)

**Chicken Pox**
Can be handled in one of three ways:
- Verified proof of the disease from doctor, parent or guardian
- Titer blood level showing immunity
- Proof of vaccination (Varivax)
Physical Examination for Nursing Program

Student Name: ____________________________  Examiner: ____________________________
(Please Print or Type)  (Please Print or Type)

Address: ________________________________  Address: ________________________________

(City)  (State)  (Zip)  (City)  (State)  (Zip)

Telephone: ____________________________  Telephone: ____________________________

In your opinion, is the current health status of the student satisfactory for clinical experience in a nursing program?

_______ Yes  ______No

If No, why not? ________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

__________________________________________  ________________________________  ______________
Date  Signature of Examining Physician or Nurse Practitioner  Examiner Phone Number

THIS PAGE MUST BE COMPLETED BY THE HEALTH CARE EXAMINER
LONE STAR COLLEGE TOMBALL

Physical Examination for Nursing Program

Name of Student: ___________________________________________________

Age: ________  Height: ________  Weight: ________  B/P: __________

Allergies: __________________________________________________________

Current Medications Taken: __________________________________________

Illnesses (Past 5 years): ____________________________________________

Injuries (Past 5 years): _____________________________________________

Past Surgeries (Type and Date): _____________________________________

Any Current Problems in the Following Areas? (If yes, please give diagnosis)

Exam Findings

Circulatory/Cardiovascular System: ______  Yes ______  No ________________

Respiratory System: ______  Yes ______  No ________________

Gastrointestinal System: ______  Yes ______  No ________________

Liver, Biliary Tract or Pancreas: ______  Yes ______  No ________________

Musculoskeletal System: ______  Yes ______  No ________________
Exam Findings

Urinary System: ______ Yes ______ No ________________________________

Reproductive System: ______ Yes ______ No ________________________________

Nervous System: ______ Yes ______ No ________________________________

Endocrine: ______ Yes ______ No ________________________________

Disorders of the Eye or Ear: ______ Yes ______ No ________________________________

Urine (Dipstick Acceptable)

__________________________________________________________
Protein Glucose Ketone Blood

Blood:

_________________________ HCT *LAB WORK MUST BE DONE

Additional Comments if necessary:

__________________________________________________________

__________________________________________________________

__________________________ ___________________________
Date Signature of Examining Physician or Nurse Practitioner Examiner Phone Number
LONE STAR COLLEGE-TOMBALL

MEDICAL HISTORY AND DISCLAIMER

Personal Information:

Name:______________________________________________________________

Address_____________________________Telephone:______________________

____________________________________________

Age:_________________ Height:___________________ Weight:______________

INCASE OF EMERGENCY:_______________________

Name of Emergency Contact _______________ Telephone Number _______________

HEALTH HISTORY: (Please check appropriate box)

<table>
<thead>
<tr>
<th></th>
<th>Never Had</th>
<th>Have Had</th>
<th>Presently Have</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
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<td></td>
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<tr>
<td>Chest pain w/exertion</td>
<td></td>
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<tr>
<td>Difficulty Breathing</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Pulmonary Lung Disease</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy</td>
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<tr>
<td>Thyroid Disease</td>
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<tr>
<td>Hypoglycemia</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Persistent Headaches</td>
<td></td>
<td></td>
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<tr>
<td>Dizzy Spells</td>
<td></td>
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<tr>
<td>Bursitis</td>
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<tr>
<td>Varicose Veins</td>
<td></td>
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<tr>
<td>Obesity</td>
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<tr>
<td>Allergies</td>
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<td>Bulimia</td>
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<tr>
<td>Anorexia Nervosa</td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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</tr>
</tbody>
</table>
List any muscle injuries you have had:_______________________________________

List any bone or joint injuries you may have had______________________________

List any muscle, bone, or joint pain you are presently experiencing:______________

Specify any medications you are presently taking:_____________________________

Specify any activities a physician has advised you to avoid:______________________

Specify any activities about which you must be cautious:_______________________

Do you smoke? Yes No If yes, how much?______________________________

Are you pregnant or have had a baby in the last six months? Yes No

Do you have any other health condition that might limit your participation in this class?__________________________________________________________________

DISCLAIMER

I accept full responsibility for any injury or accident to myself as a result of my participation in this course. Every reasonable effort will be made by Lone Star College System and its employees to make this course safe and enjoyable. I have read and understand the syllabus, course grading procedures, and the medical history and disclaimer form.

______________________________________  __________________________
Student Signature                          Date

______________________________________  __________________________
Parent or Guardian Signature if Student under 18  Date

______________________________________  __________________________
Faculty Signature                          Date
LONE STAR COLLEGE-TOMBALL

CONFIDENTIALITY STATEMENT

As a student in an LSCS health occupation program, you will have access to confidential information during your clinical experiences. Confidential information includes client information, employee information, financial information, other information relating to your duty as a student and information proprietary to other companies or persons. You may have access to some or all of this confidential information through the computer systems of the clinical facilities or through your student activities.

Confidential information is protected by strict policies of the clinical facilities and by federal and state laws particularly the Health Insurance Portability and Accountability Act. The intent of these laws and policies is to assure that Confidential Information, that is, Patient’s Protected Health Information or Individually Identifiable Information provided to students orally or contained in patient medical records or maintained on the facility’s electronic information system will remain confidential.

As a student, you are required to comply with the applicable policies and laws governing confidential information. Any violation of these laws will subject the student to discipline, which might include, but is not limited to, dismissal as a student and to legal liability.

In addition to this statement, each clinical facility may require you to sign an additional statement as you begin your clinical rotation.

Confidentiality Agreement

As a student in an LSCS nursing program, I understand that I will have access to confidential information.

I promise that:

1. I will use confidential information only as needed to perform my legitimate duties as a student.
2. I will not discuss client information outside of the clinical area and will confine any discussions to the educational conference.
3. I have participated in training regarding the privacy and security provisions of HIPAA.
4. I will safeguard and not disclose any access codes or authorizations that allows me to access confidential information.
5. I will make every effort to de-identify client information so that it cannot be connected back to the client to whom it relates.
6. I will not remove from the facility any facility generated client protected health information or individually identifiable information.
7. I will be responsible for my misuse or wrongful disclosure of confidential information and for my failure to safeguard any authorization to access confidential information. I understand that my failure to comply with this agreement may also result in my termination as a student.

____________________________________  _____________________________
Student’s signature                       Date

____________________________________  _____________________________
Print Name                               LSCS Nursing Program
STATEMENT OF ACADEMIC INTEGRITY

LSC-Tomball is committed to a high standard of academic integrity among its faculty and students. In becoming a part of the LSC-Tomball academic community, students are responsible for honesty and independent effort. Failure to uphold these standards includes, but is not limited to, the following: plagiarizing written work or projects, cheating on exams or assignments, collusion among students on an exam or project without specific permission from the instructor, or misrepresentation of credentials or prerequisites when registering for a course. **Cheating** includes looking at or copying from another student's exam, communicating or receiving answers during an exam, having another person take an exam or complete a project or assignment for you, using unauthorized notes, texts, or other materials for an exam, or obtaining or distributing an unauthorized copy of an exam or any part of an exam. **Plagiarism** means the unauthorized use of another's writings without proper documentation and includes copying material from another source without clear documentation of the source or submitting a paper, report, project, or care plan that someone else has prepared. **Collusion** is inappropriately collaborating on assignments designed to be completed independently. These definitions are not exhaustive.

When there is clear evidence of cheating, plagiarism, collusion, or misrepresentation, disciplinary action may be taken, including but not limited to: the student's presenting an oral defense, resubmitting the assignment in question, retaking an exam, receiving a zero or an F on the exam or assignment, or being withdrawn from the course or expelled.

“I have received, read and understand the LSC-Tomball-ADN statement of Academic Integrity and Code of Conduct and agree to adhere to it as stated.”

“I understand the clinical policies and procedures and all other stated policies and procedures outlined in this handbook and I agree to adhere to these policies and directives.”

Date: ________________________

Name of Instructor: __________________________________________________________

Your Name Printed: __________________________________________________________

Your Signature: _____________________________________________________________
LONE STAR COLLEGE SYSTEM-TOMBALL

STUDENT EMERGENCY PROCEDURE INFORMATION

Name:_________________________________________________________

Address:_________________________________ Telephone:_____________________

In case of emergency, illness or accident, proceed as indicated: (List order of contact 1, 2, 3, etc.)

Contact next of kin__________________________________________

Name Telephonenumber

Contact____________________________________________________

Name Telephonenumber

Contact Doctor___________________________________________

Telephone Number

Take to Hospital Emergency Room______________________________

Name of Hospital

Other Arrangements:_________________________________________

__________________________________________________________

Signature of Student Date
LONE STAR COLLEGE SYSTEM

CLINICAL, COOPERATIVE OR INTERNSHIP PROGRAM
STUDENT RELEASE OF LIABILITY

I, ____________________________, am a participant in the clinical/Cooperative/Internship Program at ________________________ and/or its subsidiaries (referred to “Company”).

While engaged in my clinical, cooperative, or internship activities, I am not an employee of Company for any purpose. However, I agree to adhere to all policies and procedures as set forth by Company.

I hereby release ______________ and/or its subsidiaries of any responsibility for any bodily injury or property damage that I incur while participating in the Program, including any injury while traveling to or from performance of work assignment. I assume full responsibility for my transportation to and from the Program, no matter how arranged.

__________________________________________  ______________
Student Signature                                Date

__________________________________________  ____________________________
Printed Name of Student                          ____________________________

__________________________________________  ______________
Witness Signature                               Date

__________________________________________  ____________________________
Printed Name of Witness                         Date
PARTICIPANT’S GENERAL INFORMATION STATEMENT AND AUTHORIZATION FOR MEDICAL TREATMENT

I (Participant) consider myself adequately and physically and mentally healthy to take full responsibility in case of illness or disability and prefer not to supply the following information.

Partipant’s Signature ___________________________ Date ______________

NAME OF PROGRAM:______________________________________________________________

NAME:___________________________________________BIRTH DATE________________________

Last                          First                          MI                          MM/DD/YY

SOCIAL SECURITY # _______________________ DRIVER’S LICENSE #_____

NAME OF SPOUSE, PARENT OR GUARDIAN______________________________________________

ADDRESS__________________________________________________________

PHONE: (     )  ______________________ (     )  _______________________________

Daytime                           Evening

Use of drugs or alcohol on a College-sponsored trip will not be tolerated under any circumstances and may be grounds for Participant’s dismissal from the Program.

PARTICIPANT’S SIGNATURE:___________________________________________________________

PARENT’S SIGNATURE: ___________________________ ___________________________

If Participant under eighteen (18) years of age
AUTHORIZATION FOR MEDICAL TREATMENT:

I, the undersigned, (print name) ______________________________ (“Participant”), I.D # _______________________

wish to (and if under 18 years of age also, my parent or guardian authorize my son/daughter to) participate in the LSCS-

sponsored Program of ______________________ (hereinafter “Program”).

MEDICAL CONDITIONS:

Please list and explain any medical conditions of the above Participant (including, but not limited to heart problems, high

blood pressure, asthma, diabetes, epilepsy, allergies, etc…)

__________________________________________________________________________

__________________________________________________________________________

Please list any allergies or allergic reactions to antibiotics or other medications of the above.

__________________________________________________________________________

__________________________________________________________________________

Please list any medication the above Participant is now taking:

__________________________________________________________________________

Date of Participant’s most recent tetanus shot: ________________________________

Other pertinent medical information: _________________________________________

MEDICAL INSURANCE;  Company:______________________________

Policy Number: ______________________________

Immunization for any disease is not required by the United States or any country we will be entering. District advises

Participant to check with Participant’s physicians and abide by their recommendation. Please list any immunizations

Participant has taken and list the dates:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
In order that I, my daughter/son (if Participant under 18), may receive the necessary medical treatment in the event of an emergency whereby I, he/she may sustain injury or illness during participation in this Program, I authorize any school official to consent to and obtain necessary medical treatment, including x-rays, examinations, anesthetic, medical or surgical diagnosis, or treatment or hospital care for such an injury or illness during the program and I hereby release discharge, indemnify and agree to hold District, District’s governing board and College and each of its trustees, employees, agents, coaches, teachers, volunteers, and representatives harmless in the exercise of its authority. I further hereby acknowledge that neither the District or any of the persons named above have any obligation to seek such treatment.

Should the need arise, the following information may be given to any health care provider:

PARTICIPANT:

NAME:__________________________________________

Last     First     Middle

ADDRESS:__________________________________________

Street     City     State     Zip

EMERGENCY CONTACTS:

Parents(s)/Guardians(s):

NAME:__________________________________________

Last     First     Middle

Phone: ( )________________________ ( )________________________

Daytime     Evening

NAME:__________________________________________

Last     First     Middle

Phone: ( )________________________ ( )________________________

Daytime     Evening

Other Contact:

NAME__________________________________________

Last     First     Middle

Phone: ( )________________________ ( )________________________

Daytime     Evening

Relationship:__________________________________________

(Friend, Relative, Neighbor, etc.)

PARTICIPANT’S REGULAR PHYSICIAN:

Name:__________________________________________

Phone: ( )________________________

I, or the undersigned parent/guardian, have read and understood the above Authorization for Medical Treatment:

Signature of Participant    Date    Signature of Parent/Guardian (If Participant under 18)    Date