Students in Health Science programs work in complex, stressful situations that require critical judgment and decision-making. It is our legal and ethical obligation to affiliating agencies and the community to ensure insofar as possible, that our students are safe and stable practitioners.

Many of the careers in Health Science require graduates to take examinations for licensure or certification. Each of these occupations has their own professional board, which has rules and regulations that are governed by law. It is the responsibility of each professional board to issue, suspend, and revoke licenses and provide disciplinary actions for infractions. Upon completion of those programs that are under a professional board, graduates must be eligible for licensure in order to secure and maintain employment.

The following information has been developed using advice from affiliating facilities, credentialing agencies’ guidelines, and Core Performance Standards for Admission and Progression that were developed by the Southern Council on Collegiate Education for Nursing. Our intent is to ensure that our students are safe practitioners, and that our graduates will be eligible for credentialing by the appropriate board and meet the requirements of employment.
All Academy of Health Professions seniors will have to complete clinical rotations as part of their medical program of studies. Below are the prerequisites for our students before they go to their clinical experiences. We recommend completing the packet during the summer break.

All seniors are required to complete the following by the due date listed below. This packet accounts for 30% of the student’s medical program grade for the first nine weeks. Completed packets and fees are due on Monday, September 10, 2018 for an “A”. The student will lose a letter grade for each day the packet is late.

1. Purchase required scrubs, scrub jacket, polo shirt, and/or lab coat. Uniforms are to be clean and ironed.
2. Purchase khaki pants if necessary for specific medical program. EMR students must purchase navy EMT pants similar to cargo pants. The pants must fit properly at the waist – not too tight or too loose. Cargo pants, denim, Capri pants and corduroy are NOT allowed.
3. Purchase white medical shoes (Must be leather or leather-like with closed toe and heel.) (EMR students need to purchase high top, non-slip sole black safety shoes/boots)
4. *All fees are the student’s responsibility: $70 for background check, $15 for Professional Liability Insurance, $13 for Student Accident Insurance, and $32 for a 10 panel drug screening for a total of $130.00. Students can pay in cash, money orders and/or checks made out to Tampa Bay Technical High School. Checks must have a printed phone number. The student’s name and student I.D. number must also be written somewhere on the check.
5. Turn in Student Information Forms – Health History and Physical Exam. TB test and flu vaccines are required prior to the first clinical rotation. The manufacturer, lot number and expiration date for the flu vaccine must be documented.
6. Turn in the Infectious/Communicable Disease Contact Release Form (must be notarized)
7. Turn in the Verification of Medical and Hospitalization Insurance form
8. Sign and Return this Clinical Requirement form
9. Turn in the Medical Release form (requires notary).
10. Turn in the Instructional Field Trip and media release forms.
11. Turn in the statement of confidentiality (requires notary).
12. Maintain a passing grade in the medical program of study. Excessive absences, unsatisfactory academic progress and/or inappropriate behavior will preclude a student from participating in clinical rotations.
13. Inappropriate behavior or dress will result in immediate removal from the clinical site and could lead to a failing grade for the clinical week.
14. No artificial nails and/or polish are allowed. No clear polish. Nails must be short.
15. Cologne or perfume is not to be worn on clinical rotations
16. Make-up must be conservative – no false eyelashes allowed.
17. Maintain hair a natural color. If hair is colored or highlighted, it must look natural; roots are not to be visible. No fancy combs or barrettes are permitted. Hair must be off the collar, pulled away from the face, and neatly secured so it is not a source of contamination.
18. No facial piercings are allowed during clinical rotations. This includes tongue piercings and clear piercing retainers.
19. Jewelry is limited to a watch with a second hand, one small stud earring per ear lobe, and a medic alert tag or bracelet. No necklaces, bracelets, or rings are to be worn.
20. Chewing gum is not allowed.
21. White socks or hose must be worn with the uniform. Socks are to cover the ankle completely.
22. Facial hair on males must be clean shaven. Beards are to be neatly trimmed.
23. Tattoos must be covered at all times. They should not be visible.
24. It may be the parent's responsibility to provide transportation to and from the clinical sites.
25. Students may not drive separately to a clinical facility if a Hillsborough County School bus has been provided to transport the student.
26. There are no breaks on clinical time. A 30 minute lunch is allowed.

*All fees are subject to change

**Student ID is required daily to attend clinical rotations.

Tentative Clinical Dates for the 2018-2019 School Year:

- October 22-26, 2018
- February 11-15, 2019
- April 9-12, 2019

Failure to comply with ALL OF THE ABOVE REQUIREMENTS will jeopardize the student's participation in the clinical experience and will affect the student's grade in his/her medical program of study.

All Academy students are required to complete 25 hours of community service for each year they have attended the Academy. Failure to complete and turn in these hours will result in not receiving the certificate of proficiency for that student's medical program.

I understand that my son/daughter will need to complete all of the above requirements and I understand and agree to follow the clinical procedures and requirements.

______________________________
Parent/Guardian Signature

______________________________
Student Signature

Date

Date

CLINICAL PROCEDURES AND REQUIREMENTS
ABSENCES/TARDIES
Each student is responsible for notifying the instructor or/and clinical facility in advance if he/she is going to be absent or tardy to the clinical experience.

PROFESSIONAL STANDARDS
A student may be referred for disciplinary action for the following reasons:
1. Violating standard safety practices in the care of patients.
2. Delaying or omitting care that is within the identified scope of practice for the chosen course of study.
3. Performing skills without an instructor’s supervision.
4. Being found in any restricted or unauthorized area.
5. Violation of confidential information related to patients and/or medical test.
6. Aggressive, rude behavior to any instructor, hospital or clinical staff, physician, patient or fellow student.
7. Leaving the clinical facility without the permission of the clinical instructor.
8. No parents, friends or family members are allowed at the facility, only for drop off and pick-up.
9. No cell phones are to be used at the clinical sites.

The clinical agency may request that a student be withdrawn from a facility for violation of the above code.

GRADING
1. The instructor will conduct evaluations weekly of students with the assistance of team leader or clinical personnel.
2. The instructor may require quizzes and/or reports.
3. Each student is required to complete a Capstone Project to achieve Occupational Completion Points.
4. Grades earned each nine weeks will be affected by attendance at the clinical site.
5. Notify instructor by email or call if there are any concerns in the clinical settings and prior to performing skills.
VERIFICATION OF MEDICAL AND HOSPITALIZATION INSURANCE

I, ________________________________ have medical and hospitalization insurance with ________________________________

Policy #: ______________ Expiration Date: ______________

I understand that I am responsible for expenses incurred from any incidents or accidents that may occur during the course of training.

X
Students Signature

X
Parental Signature

X
Date
HILLSBOROUGH COUNTY PUBLIC SCHOOLS
HEALTH SCIENCE

ACKNOWLEDGEMENT OF INFECTIOUS/COMMUNICABLE DISEASE CONTACT

RELEASE FORM

I understand that during the course of their clinical training, ____________________________
will be working with individuals, patients and/or specimens from individuals who may
have a communicable or infectious disease.

________________________________________
Signature of Parents or Legal Guardian

________________________________________
Relationship to student

________________________________________
Date

________________________________________
Signature of Notary Public
PROOF OF FLU SHOT

Student Name ________________________________

Name of Vaccination __________________________

Health Facility ________________________________

Date ________________________________

Expiration ________________________________
SCHOOL: HILLSBOROUGH COUNTY PUBLIC SCHOOLS, FLORIDA

Department of Technical & Career Education
Health Science Education

PHYSICAL EXAMINATION

TO BE COMPLETED BY APPLICANT PRIOR TO EXAMINATION

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE</th>
<th>BIRTHDATE</th>
</tr>
</thead>
</table>

ADDRESS
No./Street   Apt.   City   State   Zip Code

I understand that I may be asked to submit additional data.

Applicant’s Signature

TO BE COMPLETED BY EXAMINER

Blood Pressure: Temp: Pulse: Resp. Rate: Height: Weight

VISION SCREENING:
Right eye with glasses: Right eye without glasses:
Left eye with glasses: Left eye without glasses:

HEARING SCREENING:
Forced whisper at 5 feet: ☐ Pass ☐ Fail

REVIEW OF SYSTEMS: (+)= Positive Findings (-)= Negative Findings

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EXPLANATION OF POSITIVE FINDINGS:

Do you consider this person to be physically capable of performing the duties required in the program stated above?

Yes ☐ No ☐ ☐

Remarks:

Examiner’s Signature

Examining Physician/Nurse Practitioner/Physician Assistant

Date

Address

PHONE

Rev July 2014 Career and Technical Education – Health Science Education
**School District of Hillsborough County**

**APPLICATION FOR PARTICIPATION**  
**Instructional Field Trips**

This form is used for recording student requests to participate in instructional field trips and their parent or guardian's permission for them to participate and travel in specified transportation. It must be on file before a student may participate.

### Student Request

1. ______________________ am a student in _______________________  
   **Print Name of Student**  
   **Print Name of Class**
   
   class at _______________________ School.

2. My home address, including parent/guardian name:
   _______________________  
   **Print Parent/Guardian Name**
   
   _______________________  
   **Print Home Street Address**  
   **City**  
   **State**  
   **Zip**
   
   _______________________  
   **Home Phone**  
   **Work Phone**

The intent of this voluntary statement is to form an agreement in which I pledge my compliance with the policies in the Hillsborough County Student Handbook and to conduct myself on all field trips in such a manner as to bring honor to my school and myself in return for the privilege of being included as a participant in field trip activities.

   _______________________  
   **Student's Signature**  
   **Date of Signature**

### Parent/Guardian Request

As parent or guardian, I request that ________________________ participate in the field trip to _______________________ that will be conducted on __________ / __________ / __________.

   _______________________  
   **Print Name of Trip Destination**  
   **Month / Day / Year**

I understand that transportation for the trip will be provided by

- [ ] a private automobile of a parent, teacher, and/or licensed student, none of which is under control of School District of Hillsborough County.

  OR

- [ ] a regular school bus operated by the School District of Hillsborough County.

  OR

- [ ] a private bus under charter to the School District of Hillsborough County.

   _______________________  
   **Signature of Student's Parent or Guardian**  
   **Date of Signature**

A copy of this form must be turned into the office 3 days prior to the field trip.

*Form SB60531 revised 5/23/03*
FIELD TRIP MEDICAL RELEASE FORM

This form is used for recording parental permission for medical and/or surgical treatment in case of medical concerns on a field trip. A notarized signature is required for an overnight or out-of-state field trip.

Student Name: ___________________________ School: ___________________________
Date of Birth: ___________________________ Student #: ___________________________
Location of Field Trip: ___________________________ Date(s) of Field Trip: ___________________________

As the parent and/or legal guardian of (print student name): ___________________________, I authorize Hillsborough County Public Schools, its agents, employees, and other officers to procure and consent to any medical emergency treatment, including hospital care, to be rendered to my child by or under the supervision of a licensed health care provider. The parent/legal guardian is responsible for any fees or costs. My signature below represents consent and agreement to the matters stated above.

(Notary Stamp)

Parent/Guardian Signature ___________________________ Date ___________________________

STATE OF FLORIDA, COUNTY OF ___________________________
SUBSCRIBED and sworn to before me, a Notary Public, this __________ day of __________, 20___.
Signature of Notary: ___________________________ Print Name: ___________________________

Medical Insurance Company: ___________________________ Policy #: ___________________________
Student's Address: ___________________________ Phone: ___________________________
Father's Name: ___________________________ Phone (Day): ___________________________
Business Name (if applicable): ___________________________ Phone (Evening): ___________________________
Mother's Name: ___________________________ Phone (Day): ___________________________
Business Name (if applicable): ___________________________ Phone (Evening): ___________________________
Family Physician's Name: ___________________________ Phone: ___________________________
Physician Address (street, city, state): ___________________________

Check any health conditions that apply (if none, leave blank). Allergies __ Asthma __ Diabetes __ Seizures __ Heart condition __ Other (please describe): __
Medications prescribed: ___________________________
Hospital preference: ___________________________

NOTE: In the event of an emergency medical situation, the chaperone/teacher will call 911 and all attempts will be made to contact the student's parent/guardian regarding the emergency.
**IMMUNIZATIONS**

### RUBEOLA AND RUBELLA
Please provide proof of immunity by one of the following means (shot record, titers or current vaccinations):

- **Shot record documentation**
  - Rubeola (Measles): 2 doses live vaccine administered on or after first birthday
    - Date: __________ Date: __________
  - MMR evidence of 2 doses administered on or after 1st birthday
    - Date: __________ Date: __________

- **Titer**
  - Rubeola (Measles): 1 dose live vaccine administered on or after first birthday
    - Date: __________ Level: __________
  - Rubella (German Measles): 1 dose live vaccine administered on or after 1st birthday
    - Date: __________ Level: __________

If unable to document immunity through past vaccinations or through titer, please complete the following vaccinations:

- **Vaccinations**
  - Rubeola* (Measles) - 2 doses at least 30 days apart
    - Date: __________ Date: __________
  - Rubella* (German Measles) - 1 dose
    - Date: __________

* MMR may be given instead of individual immunizations.

### VARICELLA (CHICKENPOX)

- **History of chickenpox**
  - Yes □ No □ Date: __________
  - If no history of chickenpox, student must verify immune status with a titer.

- **Titer** (required if no history of chickenpox)
  - Date: __________
  - If titer is negative, 2 doses of varicella vaccine are recommended.

- **Vaccination** (2 doses recommended)
  - Date: __________ Date: __________

If no immunity to chickenpox, signature required.

At this time, I decline the varicella vaccinations. I understand that I do not have immunity against chickenpox and may not go into rooms with patients who have chickenpox or shingles.

Student Signature (If Declining) Date: __________

### TETANUS or TDAP
**DATE:** Proof of tetanus vaccination within the past ten years must be shown through doctor's statement or "shot" record.

### HEPATITIS B
(Applicant may choose to have a titer)

- **Titer**
  - Date: __________
- **Vaccine (3 doses)**
  - Date: __________ Date: __________ Date: __________

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious and potentially life-threatening disease.

Student Signature (If Declining) Date: __________

I certify that the above tests and/or vaccinations were performed in this office or laboratory, OR have been verified from a shot or medical record.

__________________________ [Name]  ____________________________ [Physician/Physician Assistant/Nurse Practitioner or Registered Nurse]

DATE: __________ PHONE: __________

ADDRESS: __________
HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE.
THE INFORMATION ON THE COMPLETED FORM WILL BE USED FOR COUNSELING PURPOSES AND WILL NOT BE USED TO DISQUALIFY ANY STUDENT FROM PROGRAM CONTINUATION.

<table>
<thead>
<tr>
<th>NAME:</th>
<th>PHONE:</th>
<th>BIRTHDATE:</th>
</tr>
</thead>
</table>

ADDRESS:

No./Street Apt. City State Zip Code

Have you had any serious injuries or operations within the past three years that would inhibit your ability to perform the core standards?

- [ ] YES  - [ ] NO

If YES, please explain:

CHECK ANY OF THESE CONDITIONS WHICH APPLY TO YOU:

- [ ] Bone injury or other problems that prohibit lifting 40 lbs.
- [ ] Diabetes
- [ ] Hearing problems (Surgery, hearing aid, other treatment)
- [ ] Heart disease
- [ ] Problems bending frequently
- [ ] Problems pushing objects over 50 pounds
- [ ] Seizures (convulsions, epilepsy)
- [ ] Trouble standing or walking for long periods (4-6 hours)
- [ ] Vision problems (glasses, surgery, color blindness or other treatment)

Do you have any physical or mental limitations that keep you from fulfilling the requirements of the core performance standards?

Yes_____ No_____ If yes, please explain.________________________________________________________

I have read the Student Information sheet and attest to the truth of my responses on this form. I will notify the school of any changes in my physical status.

Student signature ___________________________ Date: ___________________________
Physicians utilize a variety of methods to note results on physicals. Generally speaking, an "Ok" a "Neg.", or a "WNL" (within normal limits) are common acceptable notations.

Listed below are ranges and/or explanations that should assist you, the instructor, in reviewing areas noted numerically or with other notations. Please remember to indicate any abnormalities that may affect successful training. If the student does not fall within the established norms below, counseling for follow-up and treatment (if applicable) must be provided.

Note: There may be slight variations from one laboratory to another in the reporting of normal values.

**Blood Pressure:**
- any diastolic pressure (bottom number) 90 or above and/or
- any systolic pressure (top number) 140 or above.

**Height/Weight:**
- any excessive weight in proportion to height.

**Vision:**
- any acuity not corrected to at least 20/40

**Tuberculin Test:**
- a. Negative is normal.
- b. Positive, must show proof of x-ray.
- c. If x-ray is positive, permission to enter training must be provided by physician or health department.

**Rubella and Rubeola Screening:**
- Proof of two vaccinations or positive titer. A negative titer requires student to be vaccinated. (See Laboratory Tests and Immunization form for more specific information.)

**Varicella (Chickenpox):**
- In the absence of history of chickenpox, a varicella titer is required. Students who have a negative titer, and who decline immunization, are required to sign the statement that they must not care for patients who have chickenpox or herpes zoster (shingles).

**Tetanus (DT):**
- Must have immunization date within the last 10 years.

**DPT Booster:**
- DTAP recommended for adults students (postsecondary) and secondary student going to hospitals.

**Hepatitis B:**
- (Vaccine strongly recommended. If vaccine is declined, the declination must be signed.)

**Flu Immunization**
- Required by Healthcare facilities for students to do clinical.

Pregnant applicants must furnish a letter from their obstetrician that grants approval for program admission and which states that there are no limitations on activity or assignment.

7/2014
STUDENT MEDIA RELEASE FORM

School Name ___________________________ Student Identification Number ___________

Student Name ___________________________ Date _______________________________

Address ___________________________ City ___________ Zip ___________

Dear Parent/Guardian:

Throughout the school year, the media may visit your child's school to cover special events. Hillsborough County Public Schools may also wish to interview, photograph, or videotape your child for promotional and educational reasons to utilize in publications, posters, brochures, and newsletters; on the district web site, radio station or Cable TV channel; or other special district events.

Before your child can participate in any of the above activities, you must give your permission by signing and returning this page to your school. Thank you for your cooperation.

☐ I give my permission for my child to be interviewed, photographed or videotaped for use in school/district publications, school district productions, or for use by the general news media for print or broadcast purposes; and for his/her name to be published in school/district publications and websites, and in news publications and broadcasts.

☐ I do not give my permission for my child to be interviewed, photographed or videotaped for use in school/district publications, school district productions, or for use by the general news media for print or broadcast purposes; and for his/her name to be published in school/district publications and websites, and in news publications and broadcasts.

Parent/Guardian signature: ____________________________________________

Parent/Guardian name (please print): ______________________________________

Date: ___________________________

After you have read and signed the permission form, please return it to your child's school. The form will be retained at the school, with the student's records.

07/06
STATEMENT OF CONFIDENTIALITY

The undersigned hereby acknowledges his/her responsibility under federal and other applicable law and the agreement to keep confidential any information regarding clinical facility patients, as well as all confidential information of the clinical facility. The undersigned, agrees under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of the clinical facility.

Student Name ____________________________

Student Signature __________________________

________________________________________ Date __________________________

Parent/Guardian’s Signature

State of Florida, County of _________________ Subscribes and sworn to be a

Notary Public this ______ day of _______________ 20_____ 

Notary ________________________________
Student/Parent Clinical Agreement

Congratulations on your acceptance into one of the Academy of Health Professions medical specialty programs. We have worked hard to establish our medical magnet as a high quality place of learning and experience. We are proud of our accomplishments and know that you and your family will contribute to our continued success. The privilege of being a student in this prestigious program comes with certain responsibilities and understandings. In attending this magnet school, you have agreed to conduct yourselves in the following manner.

Student will:

- Be aware of, abide by, and follow all school, bus and clinical site rules, routines, and procedures.
- Arrive to classes on time every day prepared with necessary supplies, books and materials. Attendance at all assigned clinical rotations is mandatory.
- Complete all classwork and homework assignments.
- Follow the uniform requirements and dress code. The clinical uniform will be worn every Tuesday and Thursday starting September 11, 2018 and Monday through Friday of each clinical week. Uniforms are to be clean, neat and ironed.
- If absent during the clinical week, students will notify their instructor immediately and then notify the clinical site. Failure to do so will result in a grade of zero for the day.
- Arrive at the front of the school no later than 7:15am if riding a bus to a clinical site.
- Will attend 8th period each clinical day after returning to school. Skipping is grounds for a referral.
- Attend six hours of clinical rotations each day if driving to the clinical site. Upon reaching the site, call the instructor immediately to report arrival.
- Understand that I can be removed from the clinical site and possibly the Health Academy for misbehavior, failure to following school, bus, or facility rules and regulations and/or dress code violations.
- Store cell phones off and out of site while on clinical rotations (This includes during lunch).
- Turn in the clinical time card, journal and evaluation the first Monday after the clinical week.
- Prepare for and take the industry certification test associated with my medical program.
- Actively contribute to a positive, safe and cooperative school, bus, and clinical environment.

Parents/Guardians and family members will:

- Be aware of, abide by and follow all school, bus and clinical site rules, routines and procedures.
- Monitor the timely completion of homework assignments and my child’s grades.
- Assure students follow dress code and uniform requirements.
- Communicate with school personnel in a timely and civil manner. Absences must be reported to the school by 9am.
- Provide accurate and up-to-date contact information.

PROFESSIONAL STANDARDS

A student may be referred for disciplinary action for the following reasons:

1. Violating standard safety practices in the care of patients.
2. Delaying or omitting care that is within the identified scope of practice for the chosen course of study.
3. Performing skills without an instructor’s supervision or permission.
4. Being found in any restricted or unauthorized area.
5. Violation of confidential information related to patients and/or medical test.
6. Aggressive, rude behavior to any instructor, hospital or clinical staff, physician, patient or fellow student.
7. Leaving the clinical facility without the permission of the clinical instructor.
8. NO parents, friends or family members are allowed at the facility, only for drop off and pick-up.
9. No cell phones are to be used at the clinical sites. Using cell phones at the clinical site can be viewed as a HIPAA (Patient/Client Confidentiality) violation.

The clinical agency may request that a student be withdrawn from a facility for violation of the above code.

______________________________
Student’s Name Printed

______________________________  ________________________
Student’s Signature                       Date

______________________________  ________________________
Parent’s Signature                      Date