Health Careers Academy

Student Information Packet

Fall 2017

HCA Paperwork Checklist

- ☐ Healthcare Student Immunization Form Checklist and Instructions
- ☐ Emergency Information Card
- ☐ Medical Consent for Treatment of a Minor
- ☐ SRJC Photo Release Form
- ☐ CTE Foundation Photo Release Form

Immunization Form Checklist and Instructions

Attention Students:

Our goal is that you have an experience that provides insight into healthcare careers, and inspire you to pursue a career in healthcare.

To prepare for your time in the clinical setting it is **mandatory** that you complete the attached Healthcare Student Checklist.

Below are answers to common questions for completing the form:

Section B: Tests & Immunizations

1) Obtain your health records that list dates you received PPD tests and immunizations (also known as *vaccines).* You can obtain this information from your doctor's office.
2) The immunizations listed are usually given to children between the ages of 1 and 6 years.
3) If a test or immunization has more than one date listed, then the number of dates listed is the number required for that test or immunization. This applies to: MMR, Varicella, PPD, and the Hepatitis B Series.
4) The PPD test is given to screen for an infection called Tuberculosis. All students are required to have a PPD test twice within a 12 month period before beginning the shadow experience. The PPD tests can be placed one week apart. The **Quantiferon blood test** is not a substitute for the required two step PPD or chest x-ray.
5) If you have a positive PPD, you must have a Chest X-ray before entering the clinical setting. Your doctor will let you know if you need a Chest X-ray.
6) Tdap (Tetanus, Diptheria, Pertussis) immunization is given in childhood, usually between 11 and 12 years of age. A booster is required every 10 years. For this reason, at 19 years, most people receive a booster shot. If you do not have records of a Tdap in the last 10 years, you will need a booster. Another option is to have a blood test (known as a titer) demonstrating immunity.

How to Obtain the Two Step TB (Tuberculosis) Tests:

- Make an appointment
- Have TB# 1 placed at your clinic.
- Return to the clinic 48-72 hours (2-3 days) after TB#1 is placed to have it read by a nurse.
- Make an appointment for TB #2 at least 7 days from when #1 was placed.
- Return to the clinic 48-72 hours (2-3 days) after the TB#2 is placed to have it read by a nurse.
- Collect your results and make a copy for your immunization records.

Instrucciones y lista de verificación de forma de inmunización

Atención Estudiantes:

Nuestro objetivo es que tengas una experiencia que proporciona una idea y te inspire a seguir una carrera en la area de salud.

Para prepararse para el tiempo en un lugar clínico, es **obligatorio** que complete la lista de verificación de estudiante atención médica.

A continuación se presentan respuestas a preguntas comunes para completar el document con el medico o proveedor de salud:

Sección B: pruebas y vacunas

1.) Obtener sus registros de salud que tienen las fechas que recibió pruebas PPD y inmunización (también conocido como las vacunas). Puede obtener esta información de la oficina de su doctor.
2.) Las inmunizaciones (vacunas) que estan el la lista se dan generalmente a los niños entre las edades de 1 y 6 años.
3.) Si un examen o vacuna tiene más de una fecha indicada, el número de fechas es el número necesario para ese examen o vacuna. Esto se aplica a: la serie de Hepatitis B, MMR, varicela y PPD.
4.) Se da la prueba de PPD para detectar una infección llamada Tuberculosis. Todos los estudiantes están obligados a tener una prueba PPD dos veces en un período de 12 meses antes de comenzar la experiencia del verano. Las pruebas PPD se pueden hacer una semana apartes. **El examen de sangre Quantiferon no es un sustituto para el PPD, requiere de dos etapas o radiografía de tórax (pecho).**
5.) Si usted tiene un PPD positivo, debe tener una radiografía de tórax antes de entrar en al lugar clínico. Su médico le avisará si usted necesita una radiografía de tórax.
6.) Vacunas Tdap (tétanos, difteria, tos ferina) se dan en la infancia, generalmente entre los 11 y 12 años de edad. Un refuerzo es necesario cada 10 años. Por esta razón, a los 19 años, mayoría de las personas recibe una vacuna de refuerzo. Si no tienes registros de una Tdap en los últimos 10 años, necesita un refuerzo. Otra opción es tener un examen de sangre (conocido como un 'titer') demostrando inmunidad.

Cómo obtener las pruebas de dos paso TB (Tuberculosis):

• haga una cita
• tener TB #1 colocado en su clínica.
• Regresar a la clinica 48-72 horas (2-3 días) después de colocar TB #1 para que lo lea una enfermera.
• Haga una cita para la tuberculosis #2 al menos 7 días a partir de cuándo se colocó #1.
• Regresar a la clínica 48-72 horas (2-3 días) después de colocar el TB #2 para que lo lea una enfermera.
• Recoger los resultados y hacer una copia de tus registros de inmunización.

HEALTHCARE STUDENT IMMUNIZATION FORM

Section A: Student & Course Info

STUDENT NAME: *(Please Print)* _____ **Last Name** **First Name** **Middle Initial**	**EMAIL:** _____ **PHONE NUMBER** _____ **(Area Code) Phone Number**
_____ **Street Address** **City** **State** **Zip**	
COURSE NAME/#: HLC 121 & HLC 121L **SEMESTER/YEAR:** FALL 2017 **SECTION NUMBER:** **INSTRUCTOR NAME: Tammy Alander**	

Section B: Tests & Immunizations

Tests/Immunizations	Dates	Needed When Dates Unknown
MMR (Measles / Mumps / Rubella) Must provide documentation of 2 MMR vaccinations	**#1 MMR Date:**_____ **#2 MMR Date:**_____ Must have 2 if born after 1957. **If no MMR documentation,** **Must provide Positive Titer Results**	**MMR Titer Date if Immunization Date Unknown:**
Varicella (Chicken Pox): Must provide documentation of 2 doses of Varicella vaccine	**#1 Varicella Date:**_____ **#2 Varicella Date:**_____	Titer date proving immunity if immunization date unknown:
TB Skin Test (PPD) **Must have 2 within the last 12 months. Second PPD can be placed one week after 1st PPD placed.** If positive, must have an initial chest X-ray then complete symptoms review annually.	**#1 PPD Date & Results :**_____ **#2 PPD Date & Results :**_____	
Chest X-ray Required if TB skin test is positive. Negative X-ray requires annual symptoms review.	**X-ray Date & Result:**_____	**Symptom Review Questionnaire Required Annually** **Date Completed:**
Hepatitis B Requires positive Hep B titer or series of 3 doses. **Titer Date / Results:**_____	**If negative titer** **#1 Hep B Date:**_____ **#2 Hep B Date:**_____ **#3 Hep B Date:**_____	If vaccine declined, note date declination form signed: _____
Tdap Required once as an adult.	**Date:**	

I attest to the accuracy of the above medical information and, if requested, documentation of same will be provided on request.

Date: _____ **Verified by:** _____, **(Signature of Healthcare Provider or School Nurse)**

Name and Title PRINTED: _____

SANTA ROSA JUNIOR COLLEGE

Sport: _____
☐Fall ☐Spring Year: _____
Eligibility: ☐GS ☐RS ☐1st year ☐2nd year

Emergency Information Card

Note: *This information will be used only in the event of any emergency. Your emergency contact person will not be notified unless you give your consent or are incapacitated and are unable to make medical decisions for yourself.*

Name: _____ SSN#: ___-___-_____ Birth date: ___/___/_____ Age: _____

Local Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: (____) ____-_____ Work Phone: (____) ____-_____ Home Phone: (____) ____-_____

Email Address: _____

Are you covered under a health insurance policy? Yes _____ No _____ Is this policy an HMO or a PPO? _____

Name of the Policy Holder: _____

Name of Insurance Company: _____ Policy Number: _____

Group Name: _____ Group Number: _____

List any drugs or medications to which you have an **allergy** (e.g. penicillin) _____

_____

In Case of Emergency Notify:

1. Name _____ Relationship: _____

   Address: _____ City: _____ State: ____ Zip: _____

   Cell Phone: (____) ____-_____ Work Phone: (____) ____-_____ Home Phone: (____) ____-_____

2. Name _____ Relationship: _____

   Address: _____ City: _____ State: ____ Zip: _____

   Cell Phone: (____) ____-_____ Work Phone: (____) ____-_____ Home Phone: (____) ____-_____

ATHLETIC TRAINING ROOM CONSENT TO TREAT:

- I hereby authorize the Certified Athletic Trainers and sports medicine staff acting on behalf of SRJC to evaluate and treat any injury/illness that occurs as a result of my participation in intercollegiate athletics at SRJC. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses.
- I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission by the Team Physician, his/her delegate, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment. *The team physicians of SRJC have the FINAL authority regarding participation status following injury/illness.*
- I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and the Certified Athletic Trainer. I also agree to adhere to the established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.
- This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

Signature _____ Date ___/___/_____

Student (Parent or Guardian if under 18 years of age)

SANTA ROSA JUNIOR COLLEGE

STUDENT HEALTH SERVICES

MEDICAL CONSENT FOR TREATMENT OF A MINOR

This form is designed to permit the Santa Rosa Junior College – Student Health Services to evaluate and treat your child until she or he reaches the age of 18 unless sooner revoked in writing. It allows our office to provide the following services at each visit without requesting verbal or written consent from you:

1. **Routine student health care. (For problems such as colds, minor injuries and illnesses, cuts requiring tetanus immunization, etc.)**
2. **Emergency care, first aid, and referral to local health facilities should an emergency situation arise while your child is on the SRJC campuses.**

If you have any questions regarding this form, you are welcome to call the Student Health Services office at (707) 527 – 4445 and talk to one of our Nurse Practitioners on duty.

Student's Name_____

Social Security _____

Date of Birth _____

(I) (We), the undersigned parent(s)/guardian(s) to _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis or treatment that may be rendered to said minor child under the general or special supervision of physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such diagnosis or treatment is rendered at Santa Rosa Junior College – Student Health Services or at a licensed hospital, clinic, or doctor's office.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the staff of the SRJC Student Health Services in the exercise of their best judgment may deem advisable.

It is understood that in case of an emergency, reasonable efforts shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

This consent is given pursuant to the provisions of Section 25.8 of the California Civil Code.

_____ _____

Signature Parent or Legal Guardian (please print) Date

_____ _____ _____ _____

Address City State Zip

Telephone where Parent/Legal Guardian can be reached:

Name: _____ Home: _____ Work: _____

(please print)

SANTA ROSA
JUNIOR COLLEGE

WEBSITE, SOCIAL MEDIA AND PHOTO RELEASE FORM

I, the undersigned, hereby irrevocably consent to the unrestricted use by Santa Rosa Junior College (SRJC), of my name, personal story, and any and all photographs or video footage that SRJC has taken of me this day for all purposes, including without limitation, college art, graphics, editorial, publications, media, advertising, or trade without compensation to me.

I hereby waive any right to inspect or approve the finished photograph, verbiage, advertising copy, digital or printed products that may be used in conjunction therewith, or to the eventual use that it may be applied. In connection to the foregoing, I release Santa Rosa Junior College from all liability. Any photo negatives or digital materials will remain the property of SRJC and will not be sold or used by another agency or organization for use for commercial purposes.

I warrant that I am acting as an independent contractor, freelance, or professional without pay. This agreement constitutes the sole, complete, and exclusive agreement between Santa Rosa Junior College and me. I am not relying on any other representation whether oral or written.

Signature _____ Date _____

Name _____

Address _____

Phone _____

Witness _____

Activity _____

_____

_____

If the model is a minor, parental or guardian consent is required for participation in the interview or photo shoot. I, the undersigned, as parent or guardian of the minor whose name appears above, consent to the foregoing conditions and warrant that I have the authority to give consent.

Signature _____ Date _____

Name _____ Address _____

Phone _____ Witness _____

Office of Public Relations, Santa Rosa Junior College, 1501 Mendocino Avenue, Santa Rosa, CA 95401-4395 (707) 527-4266

CAREER TECHNICAL EDUCATION

CTE

FOUNDATION SONOMA COUNTY

Photo/Model Release Form

I, _____ do hereby give the Career Technical Education Foundation Sonoma County, the irrevocable right to use my name (or any fictional name), picture, portrait, photograph or video in all forms of media and in all manner, including composite or distorted representations, for advertising, trade, or any other lawful purposes, and I waive any right to inspect or approve the finished product, including: written copy, that may be created in connection therewith.

I hereby hold harmless and release and forever discharge Career Technical Education Foundation Sonoma County for all claims, demands, and causes of action with I, my heirs, representatives, executors, administrators, or any other persons acting on behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing and I fully understand the contents, meaning, and impact of this release.

_____

Print School/Class/Teacher

_____ _____

Signature Date

_____

Print Name

_____ _____

Signature of **Parent/Guardian** if Minor Date

_____

Parent/Guardian Printed Name

Career Technical Education (CTE) Foundation
P.O. Box 2306, Healdsburg CA 95448