VIRGINIA PENINSULA COMMUNITY COLLEGE

# NURSING EDUCATION PROGRAM STUDENT FORMS PACKET

Students granted admission into, and/or are enrolled in one or more of the College's Nursing Education Programs (courses) are responsible for executing and/or requesting the execution of various agreements, forms, documents, and/or statements of acknowledgement. These agreements, forms, documents, and/or statements of acknowledgement are part of each student's program and/or medical file and are accessible only by designated program faculty and staff.

Failure to complete any of the respective program/course required agreements, forms, documents, and/or statements of acknowledgement and/or other program required documentation by the date specified by the program/course leadership/faculty/staff may result in the student being rendered ineligible for program/course continuation.

The various Nursing Education Programs may require the execution of different agreements, forms, documents, and/or statements of acknowledgement, require submission of different medical, physical, immunization and/or medical/diagnostic testing information, certification submission, and each program may have different submission processes. The program/course leadership, faculty and/or staff will provide specific and appropriate information to students based upon their respective program/course of study, regarding the program/course documentation, and/or other submission requirements, as well as the due dates for documentation submission, and the appropriate mechanism/method of submission.

Nursing Education Program faculty and/or staff will verify compliance with the respective program/course requirements, and will notify students regarding missing, expired, and/or incomplete documentation submission.

**Failure to comply with this requirement by the published/announced due date(s) will may result in a determination of program/course ineligibility, and/or create a delay in enrollment, clinical placement, and/or other situations which create a delay, stoppage, withdrawal, and/or dismissal from your respective program/course of study.**

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

# Student Information Form

Legal Name _____ Student ID _____

Address_____ Telephone Number _____

Telephone Number _____ Telephone Number _____

VPCC Student Email Address _____@email.vccs.edu

Personal Email Address _____

Type of Medical/EMS License/Certification _____ Expiration Date _____

BLS for Healthcare Provider Certification ☐ YES ☐ NO Expiration Date _____

Have you attempted Nursing Education courses at another Virginia Community College? ☐ YES ☐ NO

If yes, please provide the course(s) number, date of last enrollment and the number of attempts.

_____ _____ _____ _____

_____ _____ _____ _____

Please provide the name of the community college where the above courses were attempted.

_____

Have you attempted Nursing Education courses at another institution/program? ☐ YES ☐ NO

If yes, please provide the course(s) number, date of last enrollment and the number of attempts.

_____ _____ _____ _____

_____ _____ _____ _____

Please provide the name of the institution/program where the above courses were attempted.

_____

If you have completed an accredited Nursing Education Program within the previous 12-month period, please complete the next section.

Date of Completion _____ Certification Achieved _____

Name of Program _____

Program Sponsor _____

Location of Program _____

Name of Program Director _____

Program Telephone Number _____

**STUDENT EMERGENCY CONTACT INFORMATION**

In case of emergency, is there someone that you would like us to contact, and do you authorize the release of information about your condition and/or location? (person listed must be at least 18 years of age)

Name_____ Relationship_____ Telephone Number_____

Age of Contact _____ Student Signature _____ Date _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## Social Media Policy Acknowledgement

I have read and understood the Virginia Peninsula Community College Nursing Education Program Social Media Policy. I agree to follow all policies, procedures and/or program requirements outlined in the policy. I understand that failure to do so may result in disciplinary action up to and including a recommendation of dismissal from the Nursing Education Program.

Student ID Number_____

Student Signature_____ Date_____

Student Printed Name _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## Photo/Video/Digital Media Release Form

I certify that my signature being affixed below on this consent form gives permission to Virginia Peninsula Community College the full right to use my photograph(s), videotaped image and sound byte in its marketing, public relations, promotional or instructional efforts. I willingly agreed to have my photograph(s), videotaped image, sound byte taken knowing that it could be used in various publications. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which may be applied.

I do hereby release to Virginia Peninsula Community College, its employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Virginia Peninsula Community College is not responsible for any expense or liability incurred as a result of my participation in this photography/video recording.

Student/Participant Name: _____

Address: _____

Telephone: _____ E-mail: _____

Signature: _____ Date: _____

For students/participants under 18 years old, a parent/guardian signature is required.

Parent/Guardian Name: _____

Address:

_____

Telephone: _____ E-mail: _____

Signature: _____ Date: _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

# Simulation Lab Latex Response Plan

POLICY: It is the policy of the Nursing Education Program to make students and employees aware that when working in the clinical setting or the nursing simulation labs, faculty and students may be exposed to latex and other allergens.

PURPOSE: To provide annual education, screening, and a review of guidelines for faculty and students to reduce the likelihood of a sensitivity or exposure reaction to latex or any other substance while in the Nursing Simulation Laboratory and to provide action steps in case of a life-threatening reaction in a nursing simulation lab.

PROCEDURE:

1. Latex Products in Use signage will be posted in each Nursing Simulation Laboratory.
2. All faculty and students will complete and sign the Latex sensitivity section at the bottom of this policy, annually.
3. Students or faculty with a known latex sensitivity/allergy should consult with their primary health care provider about their sensitivity/allergy, risks, treatment, and that in your current school/employment you will be exposed to Latex and other possible allergens.
4. Students are to inform their classroom instructor, their clinical instructor, and the simulation lab supervisor of your sensitivity/allergy to Latex.
    a. Latex-free gloves will be provided to you. Know that the lab environment and clinical facilities are **NOT** Latex free.
    b. Inform the members of your educational team noted above of your plan to respond to a reaction.
5. In case of a life-threatening reaction in a nursing lab, an ambulance will be summoned immediately.
    a. Any faculty member or student may **dial 911 on a personal cell phone or school phone, state that you have a life threatening "Latex emergency" and need an ambulance. Epinephrine will be needed.**
    b. Do not handle the victim with any latex products.
    c. Students/faculty member will be transferred to a hospital in the community by ambulance. It is helpful for the ambulance personnel to know the victims' allergies, current medications and any medical conditions.
6. A copy of this form will be given to each student/faculty member yearly. The signed original will be placed in the student /employee's permanent file.

*I have reviewed the above policy and understand that questions regarding this policy are to be directed to the Nursing Program Director and Nursing Simulation Lab Supervisor.*

Student signature_____ Date: _____

Student Printed Name_____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

# OFF CAMPUS USE OF EQUIPMENT

Before students are given selected disposable equipment for home practice, the following documentation must be completed and filed with the nursing program:

I understand that the syringes/equipment that I have received is/are to be used for practice purposes only and will remain in my possession. All used syringes shall be capped and returned to Virginia Peninsula Community College for safe and proper medical waste disposal.

Student Signature_____ Date_____

Student Printed Name _____

Virginia Peninsula Community College assumes no responsibility for any injury incurred due to improper handling or misuse of the disposable equipment.

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## Approval to Use Student Assignments

I, _____ ☐ provide / ☐ do not provide permission for any assignments, projects, photographs, and/ or videos received by instructors to be used for promotion of College and/or Nursing Education Programs I am aware these items may be displayed during my enrollment and/or after leaving the program.

Student ID Number_____

Student Signature_____ Date_____

Student Printed Name _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## Clinical and Field Facility/Site/Agency Restriction Self-Disclosure

As a student in the below Virginia Peninsula Community College Nursing Education Program:

☐ Nurse Aide ☐ Healthcare Technician

☐ Practical to Professional Nursing ☐ Professional Nursing

☐ I am not aware of any restrictions that would preclude me from being scheduled to complete clinical experiences and/or internships.

☐ I am self-disclosing to the program faculty and staff the information below related to my inability to schedule clinical experiences and/or internships at the following clinical facility, site, location, school, office, health system and/or agency:

Name of facility, site, location, health system and/or agency(s):

_____

_____

_____

_____

By my signature below, I am attesting that to the best of my knowledge, the information reported on this form is true and accurate.

Student Printed Name: _____ Student Number: _____

Student Signature: _____ Date: _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

# Student Release of Information for Clinical

Enrollment and participation in the Virginia Peninsula Community College Nursing program(s) requires that students provide proof of general and specific health status, immunization records, CPR certification, criminal background check, social security number, driver's license/photo identification card, academic records, urine/blood tests for drug screening and any other information that may be required by the college, clinical facility and/or field agency policy or legal mandate to establish students' fitness to care for live patients in a clinical and/or field setting.

The Public Safety, Allied Health & Human Services Division and the Nursing Department/Program are required to share some or all of the aforementioned information with clinical facility and/or agency partners who provide sites for the required clinical and internship/training portions of the program's courses.

Additionally, the Public Safety, Allied Health & Human Services Division and the Nursing Department/Program are required to share some or all of the aforementioned information with other entities for accreditation, course validation, certification eligibility, testing, certification issuance and/or other purposes in support of the student and/or the educational program.

Further, the Virginia Peninsula Community College, the Public Safety, Allied Health & Human Services Division and the Nursing Department/Program utilize the services of third-party software vendors for some educational/course work, as well as for the clinical and field verification and documentation purposes (a list of current software, clinical and field locations is available upon request). The the Public Safety, Allied Health & Human Services Division and the Nursing Department/Program are also required to enter some or all of the aforementioned information into software programs and/or databases not contracted by and out of the control of the College, i.e. Virginia Department of Health, American Heart Association, ACEN, etc.

Pursuant to the Family Educational Rights and Privacy Act of 1 74, 20 U.S.C. 1231g ("FERPA"), the college and/or any of it agents may not release information without the written consent of the student; subject to the exceptions specified under FERPA. You may obtain more information about Student Rights and Responsibilities (FERPA) from your course catalog, student handbook, or college website www.tncc.edu. The clinical facilities and/or field agencies are required to maintain the confidentiality of these records and may only use them to determine that a student meets the standards of the institution and thus does not present a threat to their patients or staff.

Choosing to not provide permission for the release of this information will prohibit participation in Virginia Peninsula Community College, the Public Safety, Allied Health & Human Services Division, and the Nursing Department/Program as it will result in a ban from the clinical facilities where students are required to complete the clinical portions of training. Admission to and successful completion of the clinical training portions of Nursing courses are required for program enrollment and completion.

_____

NAME OF STUDENT (Last, First, Middle Initial) STUDENT ID NUMBER

_____

ADDESS (Street, City, Zip)

_____

EMAIL ADDRESS

**PART I**

I understand that some of my records are protected under the Family Educational Rights and Privacy Act of 1974 and cannot be released without my written consent. I hereby grant permission for access to and/or the release of all applicable records described above to clinical facilities and/or field agencies and grant access to those records by agents of those clinical facilities, field agencies, agents of third-party software used for records retention and clinical/field competency validation in use by the program/courses as required for my participation in and/or completion of the Virginia Peninsula Community College, the Public Safety, Allied Health & Human Services Division, and the Nursing Department/Program and/or courses in which I am or intend to be enrolled.

I certify that this consent has been given freely and voluntarily. I may revoke this consent at any time by providing written notice of such revocation to the Virginia Peninsula Community College the Public Safety, Allied Health & Human Services Division, and the Nursing Department. Further, I understand that revocation of this consent will result in ineligibility to enroll in and/or continue in any Virginia Peninsula Community College Nursing programs/courses. This authorization is in effect for the duration of my participation and enrollment in Virginia Peninsula Community College Health Professions Division, Nursing Department/Programs and/or courses, unless revoked in writing, photocopies of this release form may be accepted, when presented in person with appropriate identification.

_____ _____
Student Signature Date

_____
Student Printed Name

**PART II - Business Partner/Employer Release of Information Authorization**

In accordance with the aforementioned documentation pertaining to the release of information and the various types of information to be released, I do hereby grant permission to Virginia Peninsula Community College, the Public Safety, Allied Health & Human Services Division, Nursing Department/Program and its authorized agents/representatives to release any and/or all of the aforementioned information to:

- RHS Facilities (including Riverside Regional Medical Center (RRMC), Riverside Behavioral Health Center, and Patriot's Colony
- Sentara Facilities (including Sentara Careplex Hospital (SCH), Sentara Williamsburg Medical Center (SWRMC), and Sentara Hospice
- Mary Immaculate Hospital
- Eastern State Hospital
- The Chesapeake

Upon request of the Company/Organization Authorized Agent/Representative.

_____ _____
Student Signature Date

_____
Student Printed Name

**IMPORTANT INFORMATION FOR ALL STUDENTS**

FAILURE TO EXECUTE PART I OF THIS FORM BY THE ESTABLISHED DEADLINE WILL RESULT IN YOUR ADMINISTRATIVE WITHDRAWAL FROM THE NURSING PROGRAM/COURSE. FAILURE OF AFFILIATED STUDENTS (WHO REQUIRE INFORMATION RELEASES TO THEIR EMPLOYER) TO COMPLETE PART I AND II OF THIS FORM RESULT IN YOUR ADMINISTRATIVE WITHDRAWAL FROM THE NURSING PROGRAM/COURSE.

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## Release and Waiver of Liability

I, _____, presently attending Virginia Peninsula Community College's ADN program, wish to participate in **CLINICALS** during the dates **January 2024** through **Decmember 2025.** I understand that participation in the above-named activity is voluntary on my part and involves an inherent risk of injury and I assume all the risks. I understand that the college may or may not provide supervision of the activity. In consideration for being allowed to participate in such activity, I understand and agree that the Commonwealth of Virginia, the Virginia State Board for Community Colleges, the Virginia Community College System, the Virginia Peninsula Community College Board, the Virginia Peninsula Community College, its agents and employees, shall not be liable to me for any injury, sickness or death or for damage to or loss of my property which may arise out of my participation in the said activity, directly or indirectly, no matter the cause, including the negligence of any such party, agent, or employee of the college. The only exception to the foregoing is in the case of injury, sickness, death, or damage caused by the deliberate and intentional wrongful act of such agent or employee in which event the agent or employee will be liable to me as provided by law.

I represent that I am over the age of eighteen (18). If under eighteen (18), my parent or legal guardian has signed below. I understand that before signing the document, I have the right to discuss it with my lawyer, family member, or any consultant of my choice.

_____ _____

Student Signature Date

_____

Student Printed Name

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## HIPAA/Medical Confidentiality Policy Acknowledgement

In connection with my duties as a student in College's Nursing Education Program, I have read and understood the Virginia Peninsula Community College Nursing Education Program HIPAA/Medical Confidentiality policies, procedures, and/or educational standards and agree to treat all clinical information concerning patients confidential. I will not divulge any information to unauthorized personnel and will safeguard the patient's right to privacy by judiciously protecting that information. I understand violation of patient confidentiality may result in disciplinary action up to and including a recommendation of dismissal from the Nursing Education Program.

Student ID Number_____

Student Signature_____ Date_____

Student Printed Name _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

# Influenza Vaccination Attestation

I understand that due to my occupational (student clinical/field internship) exposure to influenza and/or or other potentially infectious materials, viruses and diseases and that I may be at high risk of acquiring the Influenza Virus and I understand the protection the vaccination could offer and have been advised to be vaccinated at my own expense. Many and/or all of the institutional contracted healthcare are requiring and/or recommending that all healthcare workers and students be vaccinated annually with the influenza vaccine to protect themselves and the patients they serve from influenza.

In completing this form, I understand and acknowledge that I am aware of the following information:

- Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Influenza virus changes often, making annual vaccination is necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all diseases.

Vaccine Attestation: Please complete this section to confirm that you received the flu vaccine for this flu season and provide the program with documented proof of vaccination:

☐ I received the flu vaccine from _____ on _____, and I am providing proof of my vaccination status.
(name of provider/entity) (month/year)

☐ I have read and understand this document and I am declining the opportunity to receive the flu vaccine. I understand that my declination of the flu vaccine may prohibit the Nursing Education Program's ability to place me in one or more required clinical internships, and this inability to obtain clinical internship placement may result in the delay, stoppage, withdrawal and/or potential dismissal from my respective Nursing Education Program of Study.

Student ID Number_____

Student Signature_____ Date_____

Student Printed Name _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

Nursing Education Program

## Communicable Disease Statement

Upon enrollment in one or more of the Nursing Education Programs/Courses, I have been informed and am fully aware of the risks for exposure to blood and body fluids and the potential for transmission of bloodborne and other potentially infectious material and/or disease prior to, during and following patient care activities. Understanding my risks, I agree to treat all patients as assigned to me, regardless of disease state of the patient. If I refuse to treat any patient, I realize that my academic success and/or my ability to continue as a student within the Nursing Education Program may be affected by my decisions.

Student ID Number_____

Student Signature_____ Date_____

Student Printed Name _____

VIRGINIA PENINSULA COMMUNITY COLLEGE

# COVID-19
# ACKNOWLEDGEMENT OF RISK FORM

I agree that as a participant in the Nursing Education Program at one or more of the assigned/scheduled multiple clinical affiliate facilities/locations associated with Virginia Peninsula Community College (the "College") scheduled for January 2024 to December 2025, I am responsible for my own behavior and well-being. I accept this condition of participation, and I acknowledge that I have been informed of the general nature of the risks involved in this activity, including, but not limited to slips and falls, needle pricks, and contracting diseases such as COVID-19, also known as the coronavirus disease.

COVID-19 is a pandemic of respiratory disease that spreads from person-to-person. COVID-19 can cause mild to severe illness; most severe illness occurs in older adults. Nevertheless, people of all ages with severe chronic medical conditions including, but not limited to, heart disease, lung disease, and diabetes are also at a higher risk of developing serious COVID-19 illness. Healthcare workers caring for patients with COVID-19 have a higher risk of exposure and I understand that the clinical facility may have patients recovering from COVID-19. At this time, there are three vaccines approved by the U.S. Food and Drug Administration (FDA) approved for emergency use that may prevent people from getting COVID-19.

Symptoms of COVID-19 include fever or chills cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, and diarrhea. Reported illnesses range from very mild (including some with no reported symptoms) to severe, including death. If I feel sick, I agree not to go to the clinical facility and that I will stay home, except to receive medical attention if necessary. I also agree to take all necessary precautions recommended by the Centers for Disease Control and Prevention, including but not limited to, wearing a mask, staying six feet apart from others, washing my hands thoroughly and often, and avoiding crowds.

I agree to abide by any and all specific requests by the College and the clinical facility for my safety or the safety of others, as well as any and all of the College's and the clinical facility's rules and policies applicable to all activities related to this program. I understand that the College and the clinical facility reserve the right to exclude my participation in this program if my participation or behavior is deemed detrimental to the safety or welfare of others.

In consideration for being permitted to participate in this program, and because I have agreed to assume the risks involved, I hereby agree that I am responsible for any resulting personal injury or illness which may occur as a result of my participation or arising out of my participation in this program, unless any such personal injury or illness is directly due to the negligence of the College and/or the clinical facility. I understand that this Acknowledgement of Risk form will remain in effect during any of my subsequent visits and program-related activities, unless a specific revocation of this document is filed in writing with Virginia Peninsula Community College, at which time my visits to or participation in the program will cease.

I have read and understand the risks involved in participating in a clinical education program at a clinical facility during this pandemic. I understand that I have the option to postpone any clinical placement without academic penalty. I also understand that I must complete the requisite number of clinical hours to complete the health professional academic program in which I am enrolled. If I choose to postpone any clinical placement, I understand that my progression within the health professional academic program will be delayed.

In case an emergency arises, please contact _____ (Name)
at _____. (Phone number)

***I acknowledge that I have read and fully understand this document. I further acknowledge that I am accepting these personal risks and conditions of my own free will.***

_____ I represent that I am 18 years of age or older and legally capable of entering into this agreement.

_____ _____
*Student Signature* *Date*

_____
*Student Printed Name*