WESTERN CONNECTICUT STATE UNIVERSITY

DEPARTMENT OF NURSING

SOPHOMORE NURSING STUDENT

Directions for students,
The following items must be completed:

1. Create an Account on www.CastleBranch.com. It is on this site that you will upload all the information in this packet. Obtain, complete, and upload all documentation specified.

2. Keep a copy of all uploaded documentation for your records. Placement sites may request proof and you will be required to produce proof within 24 hours.

3. Included in your folder is a letter from Connecticut League for Nursing (CLN). The letter instructs the student to create an account on the CLN website in order for CLN to perform Background Checks for all nursing students. Certain results from the background check may "flag" the student as not eligible to participate in clinical. The student may not be able to be educated or sit for the licensure exam. If "flagged", the Department Chair will notify the student.

HAVE ALL HEALTH CLEARANCE FORMS
COMPLETED AND UPLOADED TO
CastleBranch.com
ON OR BEFORE
JUNE 1, 2018

Failure to Submit Forms Will Result In Written Warning or Removal from the Nursing Courses.

Reviewed 12/1/17 JHL/JP

WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING
Clinical Credentialing Requirements

Directions for *Sophomore* Nursing Students:

The following requirements pertain only to ***sophomore*** nursing students **AND** are required for WCSU clinical placements. Students **will not be allowed** to start their clinical area experience until this credentialing process is complete.

The student is responsible for obtaining and uploading all the required documentation to their CastleBranch.com Account.

NO DOCUMENTATION WILL BE ACCEPTED IN THE NURSING OFFICE.

Inaccurate and/or incomplete documentation uploaded to the CastleBranch.com Account could impact the student's eligibility to participate in clinical.

Below is a check list of the documents to be loaded to your CastleBranch.com Account.

Student Check List	Document
	Vaccine Records: Proof of titers Draws (i.e.: Lab Report.) T-Dap (good/valid for 10 years) MMR (2 vaccines) Varicella (X2 or proof of positive titer) Hepatitis B (series of three vaccinations). Physical must be up to date; cannot be more than two years old. An attestation from a health care provider will also work here. (Please review Technical Standards) PPD (placed annually)
	Release Statement (page 3 of packet)
	Technical Standards (page 4 of packet)
	Completed TB and PPD health screening form (page 5 of packet)
	Completed Health Clearance (page 6 of packet)
	Current Healthcare Provider CPR Card (i.e.: AHA or Red Cross) must be valid. It must be a **Healthcare Provider** class and include: **ADULT, CHILD and INFANT, with DEFIBRILLATOR**. **Front & Back, signatures must be visible.**
	Please note students will be also required to get a flu vaccination. The flu vaccination must be for the 2018-2019 season and it is usually available Aug/Sept 2018. You will receive an email from the Department of Nursing when flu vaccines are available and the date when it's due. **Check your WCSU email during the summer.** Proof must be uploaded to CastleBranch.com as soon as it's obtained.

In addition, student's need *Proof of Current Comprehensive Health Insurance*. It does not need to be uploaded, however, if asked to show proof, student must show they are compliant.

It is the student's responsibility to keep health information up to date and to take action to renew requirements PRIOR to the expiration date on their CastleBranch.com account. Call/Email CastleBranch first if you have trouble. If you still have trouble, then check with Dr. Palladino, Dr. Lupinacci, or Terri-Ann Tilquist by email.

The student may be issued a Classroom/Lab/Clinical warning if not compliant. The student may also be kept out of the clinical setting.

WESTERN CONNECTICUT STATE UNIVERSITY DEPARTMENT OF NURSING

STATEMENT OF RELEASE

Students who fail to provide documentation that they have met the above stated requirements **will not** be allowed in the clinical areas. A criminal background check is required prior to placement in a clinical assignment, direct cost to be incurred by the students. In certain circumstances, evidence of a criminal record may prevent a student from fulfilling clinical requirements and /or requirements for professional licensure.

I certify that I have complied with all health requirements and policies. I understand that by signing this document that I accept all responsibility for having met all contractual health requirements by the Department of Nursing, University, and agencies in which I may be assigned to do clinical*.*

I certify that I have documentation of all the above and that I will produce such documentation at the request of the Nursing Department within 24 hours of such request.

I understand that failure to meet and maintain clinical requirements will mean that I am not allowed into the clinical areas and I will not meet the program requirements.

I am aware that if during the course of the academic year(s) while participating in clinical experiences, **IF my health status should change in a way that would impact my ability to perform in clinical, I am required to notify the Nursing Department Chair and the Nursing Undergraduate Program Coordinator**. I acknowledge that I may need additional clearance which would be determined at that time.

STUDENT PRINT NAME: _____

STUDENT SIGNATURE: _____DATE:_____

Western CT State University
Department of Nursing
Technical Standards**

In order to be successful in the Western CT State University Nursing program, students should to be aware that the ability to meet the following technical standards is continuously assessed. Students in the nursing program need the ability and skills in the following domains:

- observational/communication ability,
- motor ability
- intellectual/conceptual ability
- behavioral, interpersonal, and emotional ability.

Students must be able to perform independently, with or without accommodation, to meet the following technical standards:

Observation/Communication Ability – Nursing students must be able to:

- effectively communicate both verbally and non-verbally with patients, peers, faculty, and other healthcare professionals
- use senses of vision, touch, hearing, and smell in order to interpret data
- demonstrate abilities with speech, hearing, reading, writing, English language, and computer literacy

Motor Ability – Nursing students must be able to:

- display gross and fine motor skills, physical endurance, strength, and mobility to carry out nursing procedures
- possess physical and mental stamina to meet demands associated with excessive periods of standing, moving, physical exertion, and sitting
- perform and/or assist with procedures, treatments, administration of medications, operate medical equipment, and assist with patient care activities such as lifting, wheelchair guidance, and mobility

Intellectual/Conceptual Ability – Nursing students must be able to:

- problem solve, measure, calculate, reason, analyze, and synthesize data in order to make decisions, often in a time urgent environment
- incorporate new information from teachers, peers, and the nursing literature
- interpret data from electronic and other monitoring devices

Behavioral, Interpersonal, and Emotional Ability – Nursing students must be able to:

- tolerate physically taxing workloads and function effectively during stressful situations
- display flexibility and adaptability in the work environment
- function in cases of uncertainty that are inherent in clinical situations involving patients/clients
- possess the skills required for full utilization of the student's intellectual abilities
- exercise stable, sound judgment
- establish rapport and maintain sensitive, interpersonal relationships with others from a variety of social, emotional, cultural, and intellectual backgrounds
- accept and integrate constructive criticism given in the classroom and clinical setting

I (student) attest that I have read, understood, and agree that I am able to carry out the above mentioned Technical Standards.

STUDENT PRINT NAME: _____

STUDENT SIGNATURE:_____ DATE:_____

*Approved: Student Committee DON 2/1/2010; Faculty 2/3/2010 **Adopted from SCSU Dept. of NUR Technical Standards* Reviewed*: 12/1/17*

WESTERN CONNECTICUT STATE UNIVERSITY

HEALTH SERVICES: TUBERCULOSIS (TB) SCREENING FORM

Name (Please print): Last: _____ First: _____ Date of Birth: __/__/__
Address: _____
City: _____ State: _____ Zip Code: _____ Telephone: ( ) _____-_____

PLEASE CHECK "YES" OR "NO" FOR EACH QUESTION	YES	NO
1. Have you ever had a positive tuberculosis test? If so, did you have a chest x-ray? _____ Date: _____ Were you treated with medication? _____ How long? _____ Did you ever receive BCG? _____ Please provide proof of confirmed X-ray report, results, proof of treatment and MD clearance.		
2. Were you born in the United States? If not, What country were you born in? _____		
3. Have you traveled or lived outside of the U.S. for more than 3 Months? If so where? _____		
4. Are you taking steroids, chemotherapy, radiation or drugs that affect your Immune system?		
5. Do you have any medical condition(s) that affect the immune system?		
6. **WOMEN**: Is there any possibility that you are pregnant today?		
7. ***Do you have any of the following symptoms:*** Cough, Fever, chills; night sweats and /or weight loss longer than 2 weeks?		
8. Have you received any 'live' vaccines in the past 6 weeks, i.e. *MMR, Varivax, Zoster or FluMist)?*		

I hereby acknowledge that I have received and read the information sheet entitled "Tuberculosis and the Tuberculin ***Skin Test: What you Should Know, and I have had the opportunity to ask questions about the testing procedure. I understand that if the results of my TB test are positive, that I will need to follow-up with a healthcare provider.***

Patient signature: _____Date: _____

Mantoux Purified Protein Derivative (PPD) 5 test units (0.1 ml)
Tuberculin Product (Circle One): TUBERSOL or APLISOL Lot Number: _____
Expiration Date: ___/___/___

PPD #1 Date Planted: __/__/__ **Site: LEFT or RIGHT forearm**
Result: _____mm
PPD #1 Date Read: __/__/__ **POSITIVE** **NEGATIVE**

Or Quanti FERon Gold Blood Test **Result: _____ Date_____**
This test must be done if you have received BCG.

Healthcare Provider Sign: _____

Healthcare Provider Name: _____ Title: _____

D I S P O S I T I O N: _____ _____ ____

Student Sign: _____

Student Print Name: _____ D A T E: _____

Western CT State University
Department of Nursing

HEALTH CLEARANCE TO PARTICIPATE IN CLINICAL SETTING:

(Needs to be completed by Healthcare Provider to show proof of updated physical)

SOPHOMORE NURSING STUDENT: _____

On the basis of my health assessment and physical examination, the above nursing student is free of communicable diseases and is cleared to participate in all clinical nursing activities without restrictions (please circle) Yes No

IF NO, please explain the nature of the restrictions/limitations related to the delivery of patient care:

_____

_____

_____

Date of Physical Examination: _____ Is The Student Allergic To Latex? Yes No

Today's Date: _____

Healthcare Provider Signature: _____

Healthcare Provider Name/Title: _____

License Number: _____

Office Address: _____

Office Telephone: _____

Connecticut State University Student Health Services Form

Date Beginning School ☐Fall ☐Spring of _____(year)_____

FOR OFFICE USE ONLY
☐ Complete ☐ Missing: _____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS – BOTH SIDES/PAGES OF THIS FORM MUST BE COMPLETED AND SUBMITTED

Last Name	First Name	MI
Date of Birth and Birthplace:	Sex/Gender:	**Student ID #:**

State of Connecticut and Connecticut State universities REQUIRE

Two doses for each Measles, Mumps, Rubella & Varicella—One dose of Meningitis* Complete TB Risk and/or Test or Treatment

	Vaccine & Date Given ***OR***	Incidence of Disease ***OR***	Titer Test Results (Attach lab report)	Requirements
1	Measles #1 ☐or ☐ MMR Date:	Date:	Measles Titer Date:	***Must be*** **on or after 1st birthday.**
	Measles #2 ☐or ☐MMR Date:		Result: ☐ Pos ☐ Neg	***Must be*** **at least 28 days after 1st immunization.**
2	Mumps #1 ☐or ☐ MMR Date:	Date:	Mumps Titer Date:	***Must be*** **on or after 1st birthday**
	Mumps #2 ☐or ☐ MMR Date:		Result: ☐ Pos ☐ Neg	***Must be*** **at least 28 days after 1st immunization.**
3	Rubella #1 ☐or ☐ MMR Date:	Date:	Rubella Titer Date:	***Must be*** **on or after 1st birthday**
	Rubella #2 ☐or ☐ MMR Date:		Result: ☐ Pos ☐ Neg	***Must be*** **at least 28 days after 1st immunization.**
4	~~Varicella #1~~ Date: Varicella #2 Date:	Incidence of ***OR*** Chicken Pox Disease Date: Provider Initials:	Varicella Titer Date: Result: ☐ Pos ☐ Neg	~~Varicella required only for students born on or after January 1, 1980~~ **#1 Must be on or after 1st birthday; #2 Must be at least 28 days after 1st immunization**
5	**Meningococcal (must include groups A,C,Y&W-135) If living on-campus, your last vaccination must be within 5 years of your 1st day of school.** **Date(s): 1. _____ 2. _____ Name of Vaccine: _____ ☐I will not be living on-campus. I do not require this vaccine**			
6	**TUBERCULOSIS (TB) RISK QUESTIONNAIRE –QUESTIONS A THROUGH D TO BE ANSWERED BY STUDENT**			
	A. Have you ever had a positive TB skin or blood test in the past? If you answer, "Yes," Section 6b., CHEST X-RAY, must be completed			☐ Yes ☐ No
	B. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?			☐ Yes ☐ No
	C. Were you born in one of the countries listed below? ***If yes circle country***			☐ Yes ☐ No
	D. Have you traveled or lived for more than one month in one or more of the countries listed below? ***If yes circle country.***			☐ Yes ☐ No

Afghanistan,Algeria,Angola,Anguilla,Argentina,Armenia,Azerbaijan,Bahrain,Bangladesh,Belarus,Belize,Benin,Bhutan,Bolivia,(Plurinational,State,of),Bosnia,and,Herzegovina,Botswana,Brazil, Brunei,Darussalam,Bulgaria,BurkinaFaso,Burundi,Cambodia,Cameroon,Cape,Verde,Central,African,Republic,Chad,China,China,Hong,Kong,Special,Administrative,Region,China,Macao,Special, Administrative,Region,Colombia,Comoros,Congo,Côte,d'Ivoire,Democratic, People's Republic of Korea Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial,Guinea,Eritrea,Estonia,Ethiopia,Fiji,French,Polynesia,Gabon,Gambia,Georgia,Ghana,Guam,Guatemala,Guinea,GuineaBissau,Guyana,Haiti,Honduras,India,Indonesia,Iraq,Iran,Japan Kazakhstan,Kenya,Kiribati,Kuwait,Kyrgyzstan,Lao,People's,Democratic,Republic,Latvia,Lesotho,Liberia,Libyan,Arab,Jamahiriya,Lithuania,Madagascar,Malawi, Malaysia, Maldives, Mall, Marshall,Islands,Mauritania,Mauritius,Mexico,Micronesia,(Federated,States,of),Mongolia,Morocco,Mozambique,Myanmar,(Burma),Namibia,Nauru,Niue,Nepal,Netherlands,Antilles,New, Caledonia, Nicaragua,Niger,Nigeria,Northern,Mariana,Islands,Pakistan,Palau,Panama,Papua,New,Guinea,Paraguay,Peru,Philippines,Poland,Portugal,Qatar,Republic,of,Korea,Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines,Sao,Tome,and,Principe,Senegal,Serbia,Seychelles,Sierra,Leone,Singapore,Solomon,Islands,Somalia,South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian, Arab Republic, Tajikistan, Taiwan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Trinidad and Tobago, Turks,and,Caicos,Islands,Tunisia,Turkey,Turkmenistan,Tuvalu,Uganda,Ukraine,United,Republic,of,Tanzania,Uruguay,Uzbekistan, Vanuatu, Venezuela,(Bolivarian, Republic of) Vietnam, Wallis, and, Futuna Islands, Yemen, Zambia, Zimbabwe. **Based on WHO Global TB Report 2013**

6. IF you answer **NO** to all questions no further action is required. ***Prior BCG vaccine does not exempt patient from this requirement.***

IF you answer **YES** to B-D of the above questions, Connecticut State University requires that a healthcare provider complete the following TB testing evaluation and x-ray *within 6 months prior to the start of classes.* **(After February for Fall Semester and after July for Spring Semester.)**

6a. TB BLOOD TEST OR Interferon-gamma release assay Date: Result: ☐ NEG ☐ POS	**6a. TB SKIN TEST Use 5TU Mantoux test only.**		**6b. CHEST X-RAY Required within 1 year for past or current positive TB skin or blood test. *X-RAY REPORT MUST BE ATTACHED***	**6c. TB TREATMENT Medication/Dose**
	Date Planted:	Interpretation (If no induration, mark 0) ☐ NEG ☐ POS	**Chest X-ray Date:**	Frequency: Start & Completion Dates:
	Date Read:	_____mm of induration	☐ Normal ☐ Abnormal	

Other Vaccination History (Tetanus Booster within last 10 years and Hepatitis B series are recommended)

Hepatitis B #1 Date	Hepatitis B #2 Date:	Hepatitis B #3 Date	Hepatitis Titer Result: ☐ Pos ☐ Neg Date:
Last Tetanus Booster: Td or Tdap Date:	Other Vaccination:	Other Vaccination:	Other Vaccination:

I confirm that the information above is accurate.

Clinician Signature: _____ **Date:** _____

Consent for treatment required to be signed (If you are less than 18 years of age signatures of both the student and one parent/guardian are required)

I hereby grant permission for the Connecticut State University Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions. Furthermore, I understand that University Health Services staff may disclose my student medical records and/or information from such records to appropriate University personnel and/or Emergency Contacts identified within my records in the event of a health or safety situation as determined by the Student Health Services staff.

Signature of Student _____ **Signature of Parent/Guardian** _____ **Date:** _____

Connecticut State University Student Health Services Form – Page 2

PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED

Student Name	Home/Personal Email Address	Student Cell Phone

Permanent Home Information		**Notify in Case of Emergency**	
Home Phone	Cell/Work Phone	Name	Relationship
Street Address		Home Phone	Cell/Work Phone
City	State Zip	Street Address City	State Zip
Personal Physician/Healthcare Provider Name:		Address: Telephone #:	FAX #

***Personal Medical History*- Please circle all below that apply to you:**

☐ **Check here if none apply**

Alcohol/drug Abuse	Diabetes	Mumps
Anemia	Endometriosis	Rheumatic Fever
Anxiety/Depression/Mental Illness	Gastrointestinal Problems	Seizures
Asthma	Hepatitis B or C Disease	Sickle Cell Disease
Cardiac Condition/Heart Murmur	High Blood Pressure	Thyroid Disorder
Bleeding/blood clot disorder	HIV/AIDS	Tuberculosis
Concussion	Measles	Other please explain
Dental Problems	Mononucleosis	

Allergies: Drugs & Other Severe Adverse Reactions **- Please complete all that apply and explain reaction**

Medication	Food
Insect	Environmental (pollen, animals, etc.)
Seasonal	X-ray Contrast
Are any *life threatening?* ☐ **Yes** ☐ **No**	**Do you carry an Epi Pen?** ☐ **Yes** ☐ **No**

☐ **Check here if you have no allergies**

Prior Hospitalizations or Surgeries - Please list dates and reasons:

Medications (Frequently or regularly taken) - Please list all prescriptions, natural and over the counter medications:

Is there any other medical information or health concern that we should know about? Please attach any additional information to further explain your condition or concern.

Current height**: Current weight**: Most recent blood pressure (if known) **:

Not required

Did you sign the Consent for Treatment on Page 1?

Please return by mail or fax to the appropriate Health Service listed below.

Central Connecticut State University
University Health Service
1615 Stanley Street
New Britain, CT 06050
860/832-1925 Fax 860/832-2579

Eastern Connecticut State University
University Health Service
185 Birch Street
Willimantic, CT 06226
860/465-5263 Fax 860/465-4560

Southern Connecticut State Univ
University Health Service
501 Crescent Street
New Haven, CT06515
203/392-6300 Fax 203/392-6301

Western Connecticut State University
University Health Service
181White Street
Danbury, CT 06810
203/837-8594 Fax 203/837-8583

(Rev. 8/2015)