GORDON STATE COLLEGE

DIVISION OF NURSING AND HEALTH SCIENCES

Technical Standards for Completion of Nursing Program

Verification Form

As an applicant to the Nursing Program, you have been provided a document entitled “Technical Standards for Completion of Program” and Nursing Performance Standards that you were asked to review. The physical and communication skills of the profession and similarly, the program have been identified in this document. At Gordon State College, your personal health background and/or disabilities, if any, are not known to the program faculty unless outwardly evident through personal contact or an Advocacy Letter from the Director of Counseling/ADA Coordinator. Your preparedness for the behavioral tasks of Nursing is determined by your acknowledgment to us that you do not knowingly possess any limitations that could prohibit your ability to meet the requirements and perform the functions described in the Technical Standards document.

You are asked to confirm that you have reviewed the Technical Standards and to indicate your ability to comply with the outlined requirements, through your signature below. If you have knowledge or concerns about inability to meet all standards, do not sign below, but rather explain on an attached sheet any disability(ies), citing the standard(s) that you feel you cannot meet. The Division Chair will then communicate with you to address problem area(s) in consultation with the Director of Counseling/ADA Coordinator.

I have read the Technical Standards for Nursing and attest that I am not aware of any condition and/or disability that would interfere with my ability to comply with each and every requirement outlined in the document. If any such condition should occur during my program enrollment, I agree to immediately bring my problem to the attention of the Division Chair.

___________________________________________________

Print Name

___________________________________________________  ________________________

Signature                                      Date

Witness: __________________________________________________

Date: _______________
NURSING POLICIES

Infectious Diseases

It is the policy of this Division to provide academic programs, support services, and social and recreational activities to all qualified individuals. In the event that a student is diagnosed with, or shows signs of, an infectious disease or condition, the student may be excluded from enrollment or restricted from classroom or clinical activities IF medically based judgments in each individual’s case establish that exclusion or restriction is necessary to the welfare of the individual, other members of the College community, or clients under the student's care.

Gordon State College has the responsibility to balance the rights of the ill individual to receive an education against the rights of others to function in a protected environment. In clinical situations, Gordon State College students are obligated to follow the policies and procedures of each host facility regarding infectious diseases.

Infection Control

Gordon State College nursing students are required to practice standard precautions at all times and in all clinical settings. If a student is exposed to an actual or potential infectious agent, the student must follow the guidelines of the host facility for reporting the incident and for laboratory testing. Students understand and agree that (1) testing is at the expense of the student; and (2) any testing results must be forwarded to the Dean of the School of Nursing and Health Sciences of Gordon State College.

Liability

The student understands that the clinical aspects of the nursing program may represent medical risks even when correct procedures are followed. Students understand that they are entering the clinical aspect of this program at their own risk and will not hold Gordon State College or the clinical facility liable for any illnesses or injuries resulting from these clinical experiences.

This ___________ day of ________________, 20 __________.

Student's Signature: ____________________________________________

Student's Name (printed): _______________________________________

Gordon State College ID #: _______________________________________

NURSING POLICIES

Vaccine Policy-Hepatitis B

The Division requires a physical examination of all students prior to entering the first nursing course. Immunization against hepatitis B is required. Students who decline the vaccine are required to sign a statement indicating refusal. The signed statement is kept in the student's file.

Hepatitis B

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV). It infects an estimated 200,000 people each year. Most recover, but approximately six to ten percent become chronic carriers of the virus. Some may develop chronic active hepatitis and cirrhosis. HBV appears to be a causative factor in the development of liver cancer. More than 10,000 people are hospitalized with hepatitis B annually and 250 die of fulminant disease. Recent studies indicate that immunization against hepatitis B prevents acute hepatitis and also reduces illness and death from chronic active hepatitis, cirrhosis, and liver cancer.

The virus is found in the blood and body fluids of carriers and of those with acute disease. Transmission is by contact with these fluids, through contaminated needles and syringes, and in utero from mother to infant. It affects all ages, but mostly young adults. The incubation period is two to five months.

The Vaccine

Hepatitis B vaccines are made synthetically. They do not contain blood products. You cannot get hepatitis B or other blood borne disease from the vaccine.
Hepatitis B-Student Statement of Understanding

I have read the information about hepatitis B and the hepatitis B vaccine. I understand that this information is not exhaustive and that I should discuss the issue with a health care practitioner for further information. I have had the opportunity to ask questions. I understand that the vaccine is required, but that I may refuse this immunization. I understand that the vaccination is at my own expense. I understand that some clinical facilities require that students have this immunization; therefore, my student clinical experiences may be limited because of refusal to have the Hepatitis B immunization.

This _______________ day of ________________, 20 ______.

Student's signature: ____________________________________________

Printed Name: ________________________________________________

Gordon State College ID #: ______________________________________

______ I have had the vaccine.

______ I will have the vaccine and provide the nursing program with this evidence upon completion of the series.

______ I will not have the vaccine.
A person’s right to use electronic equipment and cell phones ends when they interfere with someone else’s right to concentrate without interruption.

1. No electronic devices are to be used during class, lab, or clinical experiences. This includes text messaging, ipods, blackberries, smart phones, unless specified in a particular course book or designated as an accommodation associated with the Americans with Disabilities Act.

2. Electronic devices should be turned off or placed on vibrate if they are brought to class. If a phone or other device rings during class, the student will be asked to turn it off. If it happens twice, the student will be asked to leave the class and will be counted absent for the day.

3. Electronic devices need to be turned off during exams. If a device rings during an exam, the student will lose 25% of the starting grade (75 highest grade possible). Each time it rings, the student will lose 25% more of the starting grade (50%, 25%, 0%).

I have read and understand the rules related to electronic devices.

Student’s Signature: ________________________________

Gordon State College ID #: ________________________________

Date: ________________________________
Memorandum of Agreement with Clinical Facilities

The following documents are student-related excerpts from the Memorandum of Agreement that Gordon State College maintains with each clinical facility to which we take students for learning experiences. This agreement is to be signed as a freshman and updated annually. Please read and sign one copy, and return to the School of Nursing office.
AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION

TO: The Board of Regents of the University System of Georgia or any of its member Institutions (hereinafter referred to as the "Institution"), and any Facility where I participate in or request to participate in an applied learning experience, including but not limited to any Georgia Hospital Association member Facility (hereinafter referred to as the "Facility")

RE: ________________________________
   (Print Name of Student)

As a condition of my participation in an applied learning experience and with respect thereto, I grant my permission and authorize The Board of Regents of the University System of Georgia or any of its member institutions to release my educational records and information in its possession, as deemed appropriate and necessary by the Institution, including but not limited to academic record and health information to any Facility where I participate in or request to participate in an applied learning experience, including but not limited to any Georgia Hospital Association member Facility (hereinafter referred to as the "Facility"). I further authorize the release of any information relative to my health to the Facility for purposes of verifying the information provided by me and determining my ability to perform my assignments in the applied learning experience. I also grant my permission to and authorize the Facility to release the above information to the Institution. The purpose of this release and disclosure is to allow the Facility and the Institution to exchange information about my medical history and about my performance in an applied learning experience.

I further understand that I may revoke this authorization at any time by providing written notice to the above stated person(s)/entities, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Confidential Records and Information".

I further agree that this authorization will be valid throughout my participation in the applied learning experience. I further request that you do not disclose any information to any other person or entity without prior written authority from me to do so, unless disclosure is authorized or required by law. I understand that this authorization shall continue in force until revoked by me by providing written notice to the Institution and the Facility, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Records and Information".

In order to protect my privacy rights and interests, other than those specifically released above, I may elect to not have a witness to my signature below. However, if there is no witness to my signature below, I hereby waive and forfeit any right I might have to contest this release on the basis that there is no witness to my signature below. Further, a copy or facsimile of this "Authorization for Release of Records and Information" may be accepted in lieu of the original.
I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this "Authorization for Release of Records and Information"; and that I, or my parent and/or guardian, have read carefully and understand the above "Authorization for Release of Records and Information"; and that I have freely and voluntarily signed this "Authorization for Release of Records and Information".

This the ________________ day of ______________________, 20____

________________________________________  __________________________________________
Participant Signature                      Witness Signature

Name:____________________________________  Name:_______________________________
(Please print)                             (Please print)
STUDENT APPLIED LEARNING EXPERIENCE AGREEMENT

In consideration for participating in an applied learning experience (hereinafter referred to as the "A.L.E.") at any Georgia Hospital Association member Facility or any other Facility where I may participate in such an A.L.E. (hereinafter referred to as the "Facility"), I hereby agree to the following:

1. To follow the administrative policies, standards and practices of the Facility when in the Facility.

2. To report to the Facility on time and to follow all established regulations of the Facility.

3. To keep in confidence all medical, health, financial and social information (including mental health) pertaining to particular clients or patients.

4. To not publish any material related to my A.L.E. that identifies or uses the name of the Institution, the Board of Regents of the University System of Georgia, the Georgia Hospital Association, the Facility or its members, clients, students, faculty or staff, directly or indirectly, unless I have received written permission from the Institution, the Board of Regents of the University System of Georgia, the Georgia Hospital Association and the Facility. However, the Facility hereby grants to the Institution the right to publish Institution administrative materials such as catalogs, course syllabi, A.L.E. reports, etc. that identify or uses the name of the Georgia Hospital Association, the Facility or its members, staff, directly or indirectly.

5. To comply with all federal, state and local laws regarding the use, possession, manufacture, or distribution of alcohol and controlled substances.


7. To arrange for and be solely responsible for my living accommodations while at the Facility.

8. To provide the necessary and appropriate uniforms and supplies required where not provided by the Facility.

9. To wear a name tag that clearly identifies me as a student.

Further, I understand and agree, unless otherwise agreed to in writing, that I will not receive any monetary compensation from the Board of Regents of the University System of Georgia, the Institution or the Facility for any services I provide to the Facility or its clients, students, faculty or staff as a part of my A.L.E.
Unless otherwise agreed upon in writing, I also understand and agree that I shall not be deemed to be employed by or an agent or a servant of the Institution, the Regents or the Facility; that the Institution, Regents and Facility assumes no responsibilities as to me as may be imposed upon an employer under any law, regulation or ordinance; that I am not entitled to any benefits available to employees; and, therefore, I agree not to in any way to hold myself out as an employee of the Institution, the Regents or the Facility.

I understand and agree that I may be immediately withdrawn from the A.L.E. based upon a lack of competency on my part, my failure to comply with the rules and policies of the Institution or Facility, if I pose a direct threat to the health or safety of others or, for any other reason the Institution or the Facility reasonably believes that it is not in the best interest of the Institution, the Facility or the Facility's patients or clients for me to continue. Such party shall provide the other party and the student with immediate notice of the withdrawal and written reasons for the withdrawal.

I understand and agree to show proof of professional liability insurance in amounts satisfactory to the Facility and the Institution, and covering my activities at the Facility, and to provide evidence of such insurance upon request of the Facility.

I further understand that all medical or health care (emergency or otherwise) that I receive at the Facility will be my sole responsibility and expense.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this Applied Learning Agreement; and that I, or my parent and/or guardian, have read carefully and understand the above Applied Learning Experience Agreement; and that I have freely and voluntarily signed this "Applied Learning Experience Agreement".

This the ______________ day of ___________________ , 20___

_________________________________________  ________________________________________
Signature                                           Witness Signature

Name: __________________________________________  ________________________________
(Please print)                                        (Please print)
STUDENT REFERENCE REQUEST AND FERPA RELEASE

I request a member of the Nursing faculty to serve as a reference for me. The purpose(s) of the reference are:

- Application for employment:    Yes  No
- All forms of scholarship or honorary award.  Yes  No
- Admission to another educational institution.  Yes  No

The reference may be given orally and/or in writing. I authorize a nursing faculty member to release information and provide an evaluation about any and all information from my education records at Gordon State College, including information pertaining to my education at other institutions I have previously attended that is a part of my education record at Gordon State College, deemed necessary by the faculty member to provide the above reference.

References are requested for:

- All prospective employers:    Yes  No
- Specific employers listed below:  Yes  No

- All educational institutions to which I seek admission:    Yes  No
- Specific educational institutions listed below to which I seek admission:  Yes  No

- All organizations considering me for an award or scholarship:    Yes  No
- Specific organizations listed below considering me for an award or scholarship:  Yes  No

I understand further that:
1. I have the right not to consent to the release of my education records;
2. I have the right to receive a copy of any written reference upon request;
3. That this consent shall remain in effect until revoked by me, in writing, and delivered to the nursing office prior to the receipt of any such written revocation which will be date stamped in the nursing office.

_________________________________  ______________________________________
Student Signature        Date
Nursing Lab Conduct

1. Students must sign in and out of the practice lab.
2. Students are not allowed to eat, drink, or chew gum in the labs. Food and drinks must be kept in book bags.
3. Students are not allowed to talk or text on their cell phones while in the labs.
4. Cell phones must be turned on silent mode while in labs and must be kept in their book bags.
5. Straighten the beds and your work area after you practice.
6. Place supplies on the cart when finished practicing.
7. Only Gordon State College nursing students are permitted in the nursing labs.
8. Students should be prepared for skills by reading assignments before practicing. Your Fundamentals of Nursing is your designated resource.
9. No ink pens or printed materials are allowed around manikins. The ink will permanently stain the manikins’ skin.
10. Simulator laptops, tablets, and SimPads are to be used only by Faculty.
11. Students will respect and care for the equipment and supplies.
12. Be courteous. After you have practiced one hour let other students, who are waiting for a bed, practice.
13. Students will adhere to the policies and procedures of the Nursing Lab.
14. Students who do not follow these rules will be given a counseling note and asked to leave the lab.

I have read and understand the rules related to the nursing labs.

_____________________________                      ___________________________
Student’s Signature                                               Gordon State College ID#

____________________________                        ___________________________
Witness                                                  Date
STATEMENT OF AGREEMENT

I hereby acknowledge receipt of a copy of the Nursing Student Handbook for the Gordon State College Nursing Program. The contents of the Handbook were reviewed with me by nursing faculty members. I have read the handbook in its entirety and I understand the content. I agree to abide by and to comply with the terms, conditions, regulations, responsibilities, duties, and policies set forth in this Handbook.

The information in this Handbook supersedes all previously published information about the nursing program.

This __________ day of _________________, 20 _______.

Student Signature: ___________________________________________

Printed Name: _______________________________________________

Gordon State College ID #: ____________________________________