Allied Health and Nursing

Verification of Policy and Release of Information Form

Student is to read, initial, and sign where indicated and return to the Program Director by assigned deadline.

Statement of Student Responsibility / Confidentiality

I understand I have an obligation to conduct myself in a professional manner, follow all facility policy and procedures, and hold confidential all information concerning the patients/residents at clinical facilities and students and volunteers at Lake Superior College. I understand the unique and personal nature of client care that is involved in the education of allied health professions, and fully intend to safeguard the privacy of all clients for whom I give care, as well as their families. I will not disclose information about my clients, their families, or information about fellow students that may be obtained during my studies at Lake Superior College. I understand that this confidentiality is essential in the health profession. I agree to adhere to the professional standards of confidentiality while enrolled in my program of study at Lake Superior College. I understand any carelessness or thoughtlessness in release of any confidential information is not only ethically wrong, it may involve the clinical facility and myself legally. This may result in my not being able to progress academically. **Initial** _____

Authorization for the Release of Background Information

I hereby authorize Lake Superior College to release information contained in its files (including but not limited to reports, records, and letters or copies thereof) regarding all background studies performed for clinics/clinical placement, including but not limited to documents related to reconsideration of a disqualification, to determine my eligibility to participate in clinical placements to fulfill the requirements of my program of study at Lake Superior College. This information may be released to any of the facilities used for clinical experience. I understand that the facility will review this information to assess whether I may be permitted to participate in a clinical placement for my program of study. If background clearance is denied/not received by the Minnesota Department of Human Services, I understand that I cannot participate in clinic courses until such time as background clearance is obtained. I understand that it is my responsibility to maintain a clear background check and to follow instructions within reconsideration of disqualification, including completing subsequent background checks without expiration.

I understand that I am not legally obligated to provide this information. If I do provide it, the data will be considered private data under State and Federal Law, and released only in accordance with those laws, or with my consent. I provide this information voluntarily and understand that I may revoke this consent at any time. A photocopy of this authorization may be used in the same manner and with the same effect as the original documents. This authorization is considered current from the date of my signature until the last date of my final clinical/practicum experience. **Initial** _____

Immunizations

I understand that I am required to submit proof of vaccination and proof of titer showing immunity for all vaccines listed on the Lake Superior College "Exposure and Immunity Requirements Form." I further understand that this is a contractual requirement and if I choose not to supply this documentation, I will not be allowed to attend clinical and therefore may not be able to successfully complete my health career program. **Initial** _____

Release of Health Information

I understand that the college complies with the provisions for the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. To request accommodations, I need to provide current documentation to Lake Superior College's Disability Coordinator and determine reasonable accommodations as outlined in the College handbook. I grant Lake Superior College permission to share information contained in the "Health Declaration Form" and the "Exposure and Immunity Requirements Form" with those clinical institutions with which I affiliate in my student role, should the clinical institution request or require it. I understand that failure to sign this form or to provide the information requested may cause a clinical site to refuse me from placement at their facility. The Lake Superior College program I am studying in does not guarantee an alternative facility placement. I also understand that if no alternative facility placement is available, I may be unable to progress in a health career program. **Initial** _____

Verification of Policy and Release of Information Form

(continued)

Responsibility for Health Care Costs

Any health care costs incurred during the period of time I am a student in a health career program will be my responsibility.
Initial _____

Workers' Compensation

It is the position of the clinical facilities and Lake Superior College that, as a student, I am not an employee of either the clinical facilities to which I am assigned or Lake Superior College for purposes of Workers' Compensation Insurance.
Initial _____

Statement of Simulation Participation Expectations and Confidentiality

Learning objective for simulation in health care education include but are not limited to the following: a) apply basic to complex health skills, b) improve critical thinking skills, c) recreation of high risk/low frequency skills, d) assist in development of leadership skills and teamwork, and e) provide instant feedback and situation debriefing.

Each simulation experience is meant to offer you an opportunity to experience a mock-up of possible clinical experiences you may encounter in various health care settings and environments. It is our expectation that you participate fully in these experiences and treat the environment and the patients in the simulation as though they are real patients.

We expect professional behavior and attire when in the health simulation lab. Likewise, we expect confidentiality to be maintained so that we can facilitate a safe and structured learning environment for all health career students.

I understand that I may be videotaped during simulations for learning outcome assessment proposes and educational review by instructors and peers. I further grant permission to be photographed and/or videotaped and that these images may be disseminated for public relations reporting to Lake Superior College and the community at large. **Initial** _____

Authorization for Use and Release of Student Work

I hereby authorize Lake Superior College to use the release copies of my student work (assignments, papers, and projects, etc.) for purposes of department accreditation. **Initial** _____

Consequences for failing to comply with the above required program expectations will result in program probation and/or removal from the program.

Students are required to keep copies of all documents submitted.

- Health Forms
- Immunization Records
- CPR
- Nurse Aid

Students who become out of sequence will be required to resubmit all documentation. Students are responsible to maintain currency and submit updated documentation prior to the expiration of immunizations and CPR to the Program Director.
Initial _____

I acknowledge that I have kept a copy of my health forms and immunization records. **Initial** _____

I understand that these forms are destroyed one semester after graduation. **Initial** _____

I understand that the Lake Superior College Allied Health and Nursing programs do not provide students with copies of their required program paperwork. **Initial** _____

Student ID #_____ **Print Name**_____

Signature_____ **Date**_____