NAME: _____

(Please Print) **(Last)** **(First)** **(MI)** **Student ID #**

This checklist is being provided to assist you in completing the enrollment steps and collecting the official documents that are required for enrollment. **Note:** Once a Pre-enrollment documentation packet has been submitted, all materials will be verified. ***All materials become the property of Shasta College and cannot be returned to the students; be sure to make a copy for your records.***

Page 1 Pre-Enrollment Clinical Requirements Check-Off List

☐ ***A.*** **Clinical Requirements Checklist -** Complete program "Clinical Requirements Checklist" form

1. **CPR Certification** for Healthcare Professional or Provider Level – Adult, Infant, Child, 2-rescuer resuscitation – valid 2 years. **NO ONLINE COURSES ACCEPTED.** Must provide copy of current card.
2. **Influenza vaccine** for current Influenza season **–** Submit a copy of your original vaccine record

☐ ***B.*** **Technical Standards Disclosure Sheet** – Must be able to perform all standards listed without any or with approved accommodations. *A copy of the form must be provided to your health care provider at the time of your physical exam.*

☐ ***C.*** **Health Science Program CONFIDENTIAL Application for Clinical Practice** – Must see Dean or Program Director for any issues related to criminal history.

ACCEPTED STUDENT - CONTINUE – Complete D – I by required deadlines.

- **ALTERNATES – STOP!** – Do not complete D – I until directed by the Health Sciences Division.

☐ ***D.*** **Tuberculosis (TB) Screening Step 1**– 2-Step process is required if receiving PPD.

- **Standard PPD -** The first TB screening must be within 12 months prior to class start date and turned in with the page 1 pre- enrollment documents. The second TB screening is time-sensitive. Please see item I on page 2 for semester specific timelines and due dates.
- **Chest X-Ray -** Students with known positive PPD Tuberculosis Screening can use their recent chest x-ray and physician exam as clearance. These students must submit a completed **Confidential TB Questionnaire form** with clearance from their physician and documentation of a chest x-ray within the past two years.
- **Quantiferon Gold Blood Test –** Students not receiving the 2 Step PPD TB test or those who have previously received a BCG vaccine and chosen to obtain a Quantiferon Gold blood test for clearance must obtain a physician's order to perform this blood test. If a Quantiferon Gold blood test is ordered, **please complete this test during the Step 2 timeline listed under item I on page 2**.

☐ ***E.*** **Physical Examination –** Must be within 6-months prior to enrollment and be documented on the Shasta College Health Sciences "Health Data & Physical Examination" form.

☐ ***F.*** **Student Data Form**

This information will be kept on file while you are enrolled in the program. It is your responsibility to notify the Health Sciences office of any changes in your contact information by filling out the contact information change form available on the Health Sciences website.

☐ ***G.*** **Signed Acknowledgment Forms**

a) Use of Electronic Devices Agreement
b) Student Honor Contract
c) Photography and Publication Release
d) Assumption of Risk and Release Form

☐ ***H.*** **Criminal Background Check & Drug Screening –** *no documentation required*

Initiate process online at www.coeusglobal.com/shastacollege; complete the drug screening at a designated facility within the allotted timeframe. Visit the Health Sciences Background Check & Drug Screening Instruction page for more information.

ACCEPTED STUDENTS – Please submit copies of all original documents as outlined in items A-H above in a large manila envelope by the due date listed on your invitation letter. Incomplete packets will not be accepted. Once submitted, proceed with the time sensitive item on page 2 according to the provided timeline.

MAKE A PERSONAL COPY OF ALL RECORDS PRIOR TO SUBMISSION TO HEALTH SCIENCES OFFICE.

If you have questions, contact the Health Sciences office at (530) 339-3600

NAME: _____
(Please Print) **(Last)** **(First)** **(MI)** **Student ID #**

Page 2 Time Sensitive Pre-Enrollment Clinical Requirements Check-Off List

Time sensitive items MUST be completed between the date parameter listed for item I below and turned in to the Health Sciences Division office by the due date listed on your invitation letter.

☐ ***I.*** **Tuberculosis (TB) Screening Form & Results for Step 2**

Step 2 TB Clearance will need to be completed between the following date parameters:
Complete between January 3 – January 14
Complete only one of the following tests and the corresponding form:

- **Standard PPD -** Complete the **TB Screening form** and attach the second Tuberculosis screening results within the time frame above.

OR

- **Quantiferon Gold Blood Test –** Complete the **Confidential TB Questionnaire form** with clearance from your physician and attach documentation of a negative Quantiferon Gold Blood Test within the time from applicable to your start semester as specified above.

Documentation of all requirements and results must be on file and submitted as complete to the Health Sciences Division office by the deadline indicated on the invitation letter and Health Sciences website in order to receive your Program Enrollment Letter. **Applicants who do not submit required documentation by the deadline will be removed from the program invitation list.**

Shasta College

Health Sciences & University Programs
Clinical Requirements Checklist – Nursing/Dental Hygiene/PTA

Last Reviewed & Revised 10/5/2020

Name _____

SC STUDENT ID# _____

☐ **Associate Degree Nursing** ☐ **Physical Therapist Assistant**
☐ **Dental Hygiene** ☐ **Vocational Nursing**
☐ **Nurse Assistant/Home Health Aide**

Directions: Complete all the sections below and turn into the Health Sciences Division Office along with a copy of your official documentation. **Student is to record information on this checklist. (This form is a reporting document for Shasta College Health Sciences -- Not intended to be an official record from healthcare provider). Official documentation must be attached.**

CPR Certification - must show documentation of current certification in:	
Basic Life Support (BLS) for the Healthcare Professional including Adult, Child & Infant Resuscitation and two-person rescue. • Certification must have American Heart Association (AHA) emblem.	Expiration Date: _____

Tuberculosis Screening - must show documentation of one (1) of the following:	
A. Two negative TB skin tests (PPD) results. 1st PPD must be completed within 12 months prior to program start date. 2nd PPD must be within 6 months prior to program start date. **OR**	Date # 1 _____ Result _____ **Date # 2 due with Page 2 Check-off List or Part 2 Pre-Enrollment Packet**
B. If PPD is positive or there is a history of positive PPD, there must be a record of a negative Quantiferon Gold TB test within the past year or chest X-ray within the past 2 years. **OR**	**STUDENT AND HEALTHCARE PROVIDER TO COMPLETE THE CONFIDENTIAL TB QUESTIONNAIRE FORM**
C. If applicant has previously had the BCG vaccination, they may be eligible to take the Quantiferon Gold TB Test. (Please contact the Health Sciences office for more information.)	**STUDENT AND HEALTHCARE PROVIDER TO COMPLETE THE CONFIDENTIAL TB QUESTIONNAIRE FORM**

Influenza – to be obtained annually during the recommended flu season (September through April)	
*If you are starting in **January/March** (spring) OR **October** (fall)*: Show documentation of receiving one dose of the influenza vaccine. *If you are starting in the **August** (fall)*: You will be notified when to obtain the influenza vaccine by HSUP staff. No documentation needed at this time.	Date _____

CNA Certification – must show documentation of current certification (only of current CNAs applying to just the Home Health Aide (HHA) portion of the course):	
Current Nurse Assistant Certification from the California Department of Public Health (CDPH)	Expiration Date _____

Student Statement: I hereby certify that all materials presented and all statements made are true and correct. I authorize investigation of all records submitted and am prepared to provide original documentation when requested. I understand that any misrepresentation of material facts may be cause for immediate disqualification and removal from the program.

Signature of Applicant: _____ Date: _____

For Health Sciences Division Use Only
Date Received:
Documentation verified by:
Notes:

In the interest of your own personal safety and the safety of your patients, there are significant requirements that must be met before your admission to the program is finalized. The attendance requirements and stamina demands requires the Health Sciences student to be in good physical and mental health. Please read this form carefully and initial each technical issue standard if you can comply with the standard. When complete, please sign, date and return original in your Pre-Enrollment Clinical Requirements Packet. **Note: This is a self-assessment – to be completed by you, not a health care provider.** *Applicants must present a copy of their completed Technical Standards to their healthcare provider for review at the time of the physical examination*. **Please see the Health Sciences Dean if you require an accommodation or cannot comply with the standard.**

Issue	Description	Standard/Physical Requirement	Initials
Mobility	Physical ability, flexibility, strength and stamina	Standard work day requires various abilities including standing, walking, sitting, bending, flexing, lifting, twisting, stooping, kneeling, reaching, stretching, pushing and pulling to gather and stock supplies, operate equipment (computers, various types of medical devices, hospital beds, etc.), and perform required functions of patient care. Often must lift, carry or move objects weighing up to 40 pounds. Ability to assist patient position, transfer, or transport requiring lifting in excess of 40 pounds.	
Motor Skills	Physical ability, coordination, dexterity	Gross and fine motor abilities sufficient to perform required functions of patient care; hand-wrist movement, hand-eye coordination, and simple firm grasping required for fine motor-skills and manipulation; fine and gross finger dexterity required;	
Comprehension	Comprehend and process information; perform algebraic and complex calculations	Engage in written and oral directives related to patient care, retaining information given by faculty/ healthcare providers to assimilate and apply to patient care; comprehend and process instructions accurately; perform mathematical functions/calculations regarding medication administration.	
Tactile	Use of touch	Normal tactile feeling required. Sensitivity to heat, cold, pain, pressure, etc.	
Hearing	Use of auditory sense	Ability to hear and interpret many people and correctly interpret what is heard; i.e., healthcare provider, or supervisor orders whether verbal or over telephone, patient complaints, physical assessment (especially heart and other body sounds), fire and equipment alarms, etc.	
Visual	Use of sight	Acute visual skills necessary to detect signs and symptoms, body language of patients, color of gingival tissues, wounds, drainage, and possible infections anywhere. Interpret written words accurately, read characters and identify colors on the computer screen. Ability to read small print on medication and medical equipment.	
Critical Thinking	Ability to problem solve	Integrate information through critical thinking based on information gathered from patients during clinical sessions/ rotations, and during class sessions that are applied in the clinical process.	
Communication	Speak, read, write, & use English language effectively. Communicate effectively in interactions with others verbally, nonverbally & in written form	Effectively interacts with the environment and other persons. Fluent in English. Ability to communicate with wide variety of people and styles and to be easily understood. Reading, writing, recording, and documenting critical patient information required.	
Behavioral	Emotional & mental stability	Functions effectively under stress; flexible, concern for others; able to provide safe patient care and work in environment with multiple interruptions and noises, distractions, and unexpected patient needs.	

Print Name _____ **Student Signature** _____ **Date** _____

Indicate program of application:	
☐ Associate Degree Nursing (ADN) ☐ Dental Hygiene (DH) ☐ Health Information Technology (HIT) ☐ Health Information Management (HIM) ☐ Medical Assisting (MA)	☐ Medical Scribe ☐ Nursing Assistant/Home Health Aide (NA/HHA) ☐ Physical Therapy Assistant (PTA) ☐ Vocational Nursing (VN)

Student information:				
Last Name	First Name	MI	Maiden	
Address	City		State	Zip
Email				
Phone (day)	Phone (eve)	Phone (cell)		

Criminal Public Record Check:	
☐ Yes ☐ No	Have you ever been convicted[1] of any crime[2] under your current name or any other name? ***If the above answer is yes, please detail information for each conviction on the back of this form.***
☐ Yes ☐ No	Do you have a criminal case now pending?
☐ Yes ☐ No	Clinical assignments are in health facilities that allow access to drugs and medications. Have you ever been arrested for an offense involving controlled substances? *(Cal Labor Code 432.7f, Cal Health and Safety Code 11590)*
☐ Yes ☐ No	Clinical assignments are in health facilities that allow you regular access to patients. Have you ever been arrested for a sex offense for which registration as a sex offender would be required upon conviction? *(Cal Labor Code 432.7f, Penal Code 290)*
☐ Yes ☐ No	Do you understand that a background check; reference verification; and drug screening, is a part of the enrollment decision making process, and if you are invited to participate in the program that you consent to complete a background investigation?

[1] "Convicted" means plea, verdict of finding of no contest or guilt, regardless of whether sentence was imposed by the court.

[2] "Any crime" means misdemeanors or felonies including motor vehicle/driving violations excluding minor traffic infractions, conviction for marijuana more than two years ago, and convictions for which the records has been sealed, expunged, eradicated, or judicially dismissed.

I hereby certify that all statements made on this form are true and correct, and I authorize investigation of all statements herein recorded. I release from liability persons and organizations reporting information required by this application. I understand that any misrepresentation or falsification of material facts in this application may be cause for immediate disqualification and removal from program.

Signature of Student: _____ **Date:** _____

**Existence of convictions will not necessarily disqualify an applicant from enrollment. However, failure to fully disclose may be considered falsification and will result in offer of enrollment being rescinded; and is grounds for immediate termination upon discovery at any time during enrollment.*

Information Regarding Criminal History:			
Date	**Conviction**	**Conviction Type** (misdemeanor/felony)	**Court Name & Location** (city & state)
Example: 1/1/2010	Driving under the Influence (DUI)	Felony	Shasta County Superior Court Redding, CA

Exclusion from Clinical Placement

In collaboration with the clinical agencies used by Shasta College, a student will be excluded from participation in clinical rotations and therefore unable to complete the Shasta College Health Sciences programs for the following background check/drug screen findings:

- Capitol felony conviction at any time in student's past
- Felony conviction within past 7 years[3]
- Misdemeanor convictions with past 3 years[3]
- Medicare fraud
- Any crime that results in requirement to register as a sex offender
- Positive drug screen

[3]Note: Felony or misdemeanor convictions involving crimes against persons or property, any drug charges, and driving under the influence must fall outside the above time lines for students to be eligible for enrollment.

For more information regarding clearance needed to apply for certification or licensure, please contact the accrediting board for your program.

Signature of Student: _____ **Date:** _____

**Existence of convictions will not necessarily disqualify an applicant from enrollment. However, failure to fully disclose may be considered falsification and will result in offer of enrollment being rescinded; and is grounds for immediate termination upon discovery at any time during enrollment.*

Part I: To be completed by Student:

Indicate program of application:	
☐ Associate Degree Nursing (RN)	☐ Medical Scribe
☐ Dental Hygiene (DH)	☐ Nursing Assistant/Home Health Assistant (NA/HHA)
☐ Health Information Technology (HIT)	☐ Pharmacy Technician
☐ Health Information Management (HIM)	☐ Physical Therapist Assistant
☐ Medical Assisting (MA)	☐ Vocational Nursing (LVN)

Applicant information:				
Last Name	First Name		MI	Maiden
Address	City		State	Zip
Email Address	Birth date	Gender ☐ M F ☐		
Phone (day)	Phone (eve)		Phone (cell)	

Person to notify in case of emergency:			
Full Name		Relationship	
Address – Number & Street	City	State	Zip
Home Phone	Work Phone	Cell	

HEALTH HISTORY

Please rate you current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Certain minimum physical abilities and characteristics are required in health sciences professions. Do you have any condition that would interfere with your ability to perform the minimum technical skills standards for the program to which you are applying?

☐ Yes ☐ No If yes, explain: _____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Allergies/sensitivities (i.e. medications, foods, Latex/Powder): Please List: _____

_____

Do you have any lifting restrictions: ☐ Yes ☐ No If yes, explain: _____

_____

The information provided is true and correct to the best of my knowledge. I am aware that any change in my physical or mental health, including pregnancy, during the program may require that I obtain medical clearance to continue in the program.

Student Signature: _____ Date: _____

HEALTH DATA & PHYSICAL EXAM FORM (continued)
FOR HEALTH CARE OCCUPATIONS

Applicant Name:	Date:

Part II: To be completed by health care provider

☐ I have reviewed the student's Technical Standards Disclosure form

Does your examination of the student reveal any limitations in the following:			
SPINE: ☐ Yes or ☐ No	LIFTING: ☐ Yes or ☐ No	PROLONGED STANDING: ☐ Yes or ☐ No	
PROLONGED SITTING: ☐ Yes or ☐ No		BENDING: ☐ Yes or ☐ No	☐ **NO LIMITATIONS OF ANY TYPE**

Based upon today's subjective/objective exam and the disclosed health history, does this student have any health condition that would create a hazard to self or others, or limit their ability to provide health & patient care and/or services?

☐Yes ☐ No ☐ Any health condition is under observation and/or treatment and does not create a hazard

If yes, explain:

Physician or Approved Licensed Health Professional Information:	
Agency or Clinic providing service (*Name & Address or Facility Stamp*)	
Printed Name	Title
Signature	Date

Date _____

Student Data

This information is to be kept on file while you are a student in the Physical Therapist Assistant program.

Student Name:

_____

Student ID# _____

Age: ____ Birthdate: _____

☐ Male ☐ Female

Address:

_____

_____

County of Residence: _____

Email: _____

Phone: _____

Did you take prerequisite courses from another college: ☐ **Yes** ☐ **No**

If yes, where: _____

Are you a re-admit student from the Shasta College PTA program? ☐ **Yes** ☐ **No**

Are you a veteran? ☐ **Yes** ☐ **No**

Are you sponsored by: ☐ **Smart Center** ☐ **CalWORKs** ☐ **other**

Are you receiving Financial Aid for school? (Pell Grant, Scholarship, Loan) ☐ **Yes** ☐ **No**

What language other than English do you speak? _____

(Fluent enough to conduct a patient history or assessment)

Ethnic Background:

- ☐ **Asian**
- ☐ **Black**
- ☐ **Caucasian**
- ☐ **Filipino**
- ☐ **Native Hawaiian**
- ☐ **Other**
- ☐ **Hispanic**
- ☐ **Native American**
- ☐ **Pacific Islander**
- ☐ **Asian Indian**
- ☐ **Mixed**

Use of Electronic Devices Agreement

I have reviewed and sought clarification of the Standards for Use of Electronic Devices. I am aware that I can find the Standards for Use of Electronic Devices online.

I understand these standards are designed to protect individual and patient rights and that I have the responsibility to be aware of confidentiality issues and maintain appropriate conduct in the use of electronic devices both during classroom/clinical skills sessions and during clinical experiences in the healthcare facilities.

I understand that violation of the standards for use of electronic devices in the classroom and clinical skills lab setting will result in the loss of the privilege of using such devices to support my learning strategies and may result in being placed on contract by instructor.

I understand that violation of the standards for use of electronic devices during clinical experiences in the healthcare facilities and within patient care areas will result in the loss of the privilege of using such devices to support my clinical care activities and learning and will result in being placed on contract by my instructor.

I understand that violation of the standards may result in HIPAA violation claims against me and that I could be liable for consequent legal action.

In addition, I understand that according to the program's Dismissal policy, a HIPAA violation is cited as an example of an incident or clinical situation that puts the patient, student, clinical affiliate, faculty or college at risk and therefore, deems the student subject to dismissal from the Health Science program.

This agreement will be placed in my student file.

_____ _____
Name of Student (Printed) Date

_____
Name of Student (Signature)

Health Science Program Honor Contract

I understand that Health Sciences Division Program students are expected to maintain an environment of academic integrity. I further understand that actions involving scholastic dishonesty violate the professional code of ethics. I have been informed and understand that any student found guilty of scholastic dishonesty is subject to dismissal from the Health Science Program and may be ineligible for re-admission.

I have read the Scholastic Honesty Standard in the Health Sciences Program Student Handbook. I understand the Scholastic Honest Standard and I agree to fully abide by this stated policy.

_____ _____
Name of Student (Printed) Date

_____
Name of Student (Signature)

Student Photography and Release Policy

Photographs of the student may be taken during course activities (non-client contact) and utilized by the program for professional educational activities (i.e. bulletin boards, audiovisual presentations, pamphlets, catalogues, websites, etc.).

It is the responsibility of the student to notify the photographer at the time if they do not wish to have their photograph taken or utilized. Signing the Shasta College Publication Release Form signifies that the student has read and understood this policy, and gives the college permission to use the print or digital reproduction at its sole discretion.

Publication Release Form

I have voluntarily agreed, without compensation of any kind, to appear or allow my art work or image to appear in any print, film, digital likeness or videotape produced by the Shasta-Tehama-Trinity Joint Community College District.

The Shasta-Tehama-Trinity Joint Community College District shall have the right and may grant to others the right to disseminate, print, alter and publish my name, likeness and biographical material, in connection with any publicity and promotion of the print, film, digital likeness, videotape or art work, except for the direct endorsement of any product.

I hereby release and discharge the Shasta-Tehama-Trinity Joint Community College District and its respective agents, employees, successors, assigns, and licensees from any and all claims, liabilities and obligations of any kind of nature that may arise from my appearance or participation or art work incorporated in the print, film, digital likeness or videotape of any exhibition thereof.

I agree that the Shasta-Tehama-Trinity Joint Community College District has no obligation to exhibit or televise my performance or art work or otherwise use my likeness or art work in its print, film, digital or videotape.

Signature: _____

Print Name: _____

Date: _____

I, _____, wish to enroll in and participate in the following class:
Print Name

Indicate program of application:	
☐ Associate Degree Nursing (RN)	☐ Medical Scribe
☐ Dental Hygiene (DH)	☐ Nursing Assistant/Home Health Assistant (NA/HHA)
☐ Health Information Technology (HIT)	☐ Pharmacy Technician
☐ Health Information Management (HIM)	☐ Physical Therapist Assistant
☐ Medical Assisting (MA)	☐ Vocational Nursing (LVN)

Please initial each of the following statements.

____ **Release of Liability and Waiver**: In return for being permitted to enroll and participate in the above Program, including any associated use of the premises, facilities, staff, equipment, transportation, and services of the Shasta-Tehama-Trinity Joint Community College District (District), I, for myself, heirs, personal representatives, and assigns, **do hereby release, waive, discharge, and promise not to sue** the District, the Board of Trustees, directors, officers, employees, and agents (collectively the "District"), from liability **from any and all claims, including the negligence of the District**, resulting in personal injury (including death), accidents or illnesses, and property loss in connection with my participation in the Program and any use of District premises and facilities.

____ **Assumption of Risks: I understand that enrollment and participating in the Program** involves the risks associated with blood borne pathogens and the other activities described in the course outline of record. I further understand that certain inherent risks in the Program cannot be eliminated regardless of the care taken to avoid injuries.

I have been advised and am aware of the risks associated with enrolling and participating in the Program, which include but are not limited to physical or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability (including paralysis), economic or emotional loss, and/or death. I understand that these injuries or outcomes may arise from my own or other's actions, inaction, or negligence or the condition of the Program location(s). Nonetheless, I assume all related risks, both known or unknown to me, of my participation in the Program and further agree to accept all Program rules and requirements for the program participation, travel policies, program schedules, and to follow the instructions given by supervisory personnel involved in the program and related classes.

I am voluntarily participating in the Program and I acknowledge and fully assume the risks associated with my enrollment and participation.

____ **Indemnification and Hold Harmless:** I also agree to **indemnify and hold the District harmless** from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, arising out of my involvement in the Program, and to reimburse it for any such expenses incurred.

____ **Medical Certification and Consent:** I certify that I am physically capable and have received medical clearance for participating in the Program and that I have no medical condition which would interfere with my ability to safely participate. In the event of any medical emergency, as determined by District supervisory personnel, I authorize and consent to any x-ray examination, anesthetic, medical, dental or surgical procedure or treatment, and hospital care deemed necessary for my safety and protection.

Signature required on Page 2

____ **Governing Law and Severability**: I understand that this document is written to be as broad and inclusive as legally permitted by the State of California and agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms. I agree this Agreement shall be governed by the laws of the State of California, and any disputes arising out of or in connection with this Agreement shall be under the exclusive jurisdiction of the Courts of the State of California.

____ **Understanding and Acknowledgement:** I have read all previous paragraphs, including the release of liability and waiver, assumption of risk, and indemnity agreement, know, fully understand its terms, acknowledge these and other risks that are inherent to the Program, and **understand that I am giving up substantial rights, including my right to sue. I acknowledge my participation is voluntary, that I knowingly assume all such risks**, and that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the extent allowed by law. No other representations concerning the legal effect of this document have been made to me.

I am 18 years or older. I have read this document and fully and completely understand the potential risks that may be associated with the Program. I am signing this document freely.

Participant's Name: _____

Signature: _____ Date: _____

If Participant is under 18 years of age: I am the parent or legal guardian of the Participant. I have read this two-page document, and I am signing it freely. I understand the legal consequences of signing this document, including (a) release of District from all liability on my and the Participant's behalf, (b) waiver of my and the Participants' right to sue, (c) and assumption of all risks of the Participant's participation in the Activity including travel to and from. I allow Participant to participate in this Activity and I understand that I am responsible for the obligations and acts of Participant as described in this document. I agree to be bound by the terms of this document.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

Tuberculosis Screening

As per Health Sciences Program Policy - Clinical Requirements, the result of a Two-Step TB screening is required as part of enrolling in a Health Sciences program.

Complete and submit this form with healthcare provider documentation of results attached.

STOP! If you have ever had a positive PPD which required you to have a QuantiFERON Gold TB test or chest x-ray, **you must not** take further PPD tests. Please refer to the Clinical Requirements policy and/or talk with your healthcare provider or Health Services staff for more information. If you have had a BCG vaccine, you may be eligible to use the QuantiFERON Gold TB test instead of x-ray and medical clearance.

Name: _____ Age: _____ Date: _____

Student ID#: _____ Date of Birth: _____

Phone #: _____ Email: _____

NEW STUDENTS:

Date Administered #1: _____ **Result:** ☐Positive ☐Negative

Date Administered #2: _____ **Result:** ☐Positive ☐Negative

Attach a copy of the 2nd TB screening administration and interpretation form from your health care provider.

I am at least 18 years of age and verify that I have completed the 2-Step Process for Tuberculosis Screening with 2 negative test results within the prior 12 months, the second of which is within 6 months prior to enrollment in my Health Science program (or within 90 days of starting clinical for the NA/HHA program only).

_____ **Date:** _____

(Student Signature)

CONTINUING STUDENTS:

Date Administered: _____ **Result:** ☐Positive ☐Negative

Attach a copy of the TB screening administration and interpretation form from your health care provider.

I am at least 18 years of age (under 18 requires written parental consent) and verify that I have completed a Tuberculosis Screening Skin Test.

_____ **Date:** _____

(Student Signature)

All students applying for Health Sciences Programs will need to have a current CPR certification that meets five (5) specific criteria. The selected course must be at the **(1)** ***Healthcare Provider*** level. The course will include **(2)** Basic Life Support (BLS) for adult, child and infant CPR and **(3)** 2-rescuer resuscitation with hands-on practicum and testing. The certification card issued must include the **(4)** American Heart Association (AHA) logo and **(5) No online courses are accepted.**

WHERE CAN YOU OBTAIN A CPR CERTIFICATION FOR A HEALTH PROFESSIONAL?

Shasta College course – FAID 133
11555 Old Oregon Trail
Website: shastacollege.edu

A+ SAFETY – (530) 222-1210
2765 Bechelli Lane, Redding CA 96002
Website: aplussafetyllc.com

CENTER FOR EXCELLENCE IN EDUCATION - (530) 891-8916
Peggy Tyranski - pstyranski@gmail.com
Website: CEEMED.com

Kiser CPR & First Aid – (530) 921-1455
4425 Tralee Lane, Redding, CA 96001
Website: kisercpr.com

MED ED – (530) 276-9164
1615 Continental Street, Redding CA
donnaconrad@shasta.com

Additional resources within our community may meet the criteria listed above as well.