

Hinds Community College Nursing and Allied Health Programs Clinical Record Packet



General Directions & Information

All clinical requirements must be submitted by the health profession program's designated due date. Failure to submit Clinical Record Packet requirements by the due date will result in disruption in progression. Attendance guidelines will be enforced. For questions about program deadline dates or satisfactory completion of requirements, contact the appropriate program representative listed on last page of this packet.

The clinical requirements are to be submitted as a **complete packet with all components listed in the order listed on page 3.**

Write your Hinds Community College ID# on each document that you submit.

**The clinical requirements must have a date that will be current for the entire semester.
Altered documents will not be accepted!**

Make a copy of all documents for complete health packets and documents being up-dated PRIOR to submission! This includes student's health history, physical exam form (to include records from pharmacies for prescription drugs), appropriate lab work (titers), TB test, Chest X-ray or IGRA, immunizations, and CPR Card. Copies will NOT be made when handing in records.

Should a student return to the Health Clinical Records Department for a copy, there will be a charge of \$5.00 per page requested.

For questions or information about the Health Record Packet contact:

Clinical Records Clerk

Nursing/Allied Health Center

1750 Chadwick Drive, Jackson, MS

601.376.4806

Student Services Office, Anderson Hall, Suite 6

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Program Representatives

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Short-Term [Nursing Assistant & Phlebotomy]
Reorientation to Nursing
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Submit paperwork in the order presented in the table.

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204

Submit paperwork in the order presented in the table.

Clinical Record Requirements

DO NOT TURN IN DOCUMENTATION WITHOUT MAKING A COPY!!

The following are requirements for all students entering a health professions programs:

Completed Health History Upon Admission & Annually Thereafter To be completed by the student, Page 5.	
Completed Physical Exam Form Upon Admission & Annually Thereafter To be completed by physician or certified nurse practitioner within three months prior to the published due date, i.e., if due on August 1, must have be completed no earlier than May 1 st . All areas must be completed on the Hinds Community College approved form on page 5.	
*Tetanus, Diphtheria, & Pertussis Proof of immunization for all three (3) infections listed above, in the past ten years. TDaP is the acceptable immunization for all three, and is available at the Hinds County Health Department. (contact your local health department)	
* Varicella Titer or Copy of immunization record verifying proof of two Varicella immunizations. A positive IGG Varicella titer is required (if there is no proof of two Varicella immunizations) and must be completed by the program deadline. Vaccinations are required if the Varicella titer is negative. Note: There is a waiting period of at least thirty days between the two injections. There must be at least fourteen days between the last injection and the first day of clinical.	
* TB skin test, chest x-ray (CXR) or IGRA, Upon Admission & Annually Thereafter A record of negative results from TB skin test, CXR or IGRA (QuantiFeron Gold® or T-Spot) is required upon admission and annually thereafter. Note: The CDC recommends a two-step TB skin test initially for all health care providers. Whenever there is more than 1 year between TB skin tests a two-step is required.	
*MMR (2) Two MMR's or proof of a positive titer for each of the following: measles, mumps and rubella. If born before 1957, only 1 injection is required.	
Hepatitis B Immunization/Immunity A complete series of three scheduled immunizations is strongly recommended for all programs. A positive Hepatitis B titer can be substituted for a complete series. Note: Students are required to have one of the following: a complete series, a positive titer, or a declination statement. Students will be required to sign a Blood-Borne Pathogens and Tuberculosis Training Statement following required OSHA training (this includes a declination statement).	
*Flu Vaccine Annually between October 1 & November 1 Flu vaccines are required annually in the fall between Oct. 1 and Nov. 1. Students returning in the spring and summer semesters must show documentation of flu vaccine between Oct. 1 of the previous year and the beginning of the semester. Students have the right to request medical or religious exemption but the agency may not allow exemptions and has the right to deny clinical experiences to the student, or may require the student to wear a mask for an entire clinical experience.	
CPR: Upon Admission and Every 2 Years Thereafter Proof of current American Heart Association BLS Provider Certification with a signed card. Copy front and back of card. A copy of the BLS Provider eCard is also acceptable. Letters stating student has completed a BLS course and is awaiting a CPR Card will only be accepted from Hinds Community College's continuing education department.	
Background Records Check: Upon Admission and Every 2 Years Thereafter All students must complete a criminal background check from the Nursing/Allied Health Center. Students who have any eliminating background record will not be allowed admission to any nursing or allied health program. A student may also be denied the ability to progress in a program of study based on eliminating background information. Students will be contacted to schedule an appointment. Please check your Hinds Community College e-mail for messages. For more information, review the procedure in the NAH Student Manual on the Health Related Professions page of the College website: http://www.hindscc.edu (Programs of Study to Nursing and Health Related Programs to Nursing and Allied Health Student Manual)	

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Nursing and Allied Health Programs
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Note: A complete health packet includes copies of the student's health history, physical exam form (to include records from pharmacies for prescription drugs), appropriate lab work (titers), TB test, Chest X-ray or IGRA, immunizations, and CPR Card. Include your Hinds ID# on each page that is submitted as part of the health packet. Incomplete packets will NOT be accepted by the Health Records Clerk. **MAKE A COPY FOR YOUR RECORDS PRIOR TO TURNING IN HEALTH PACKET!**

Continuing Nursing and Allied Health Students' Clinical Requirements

Continuing Nursing and Allied Health Students are required to complete the following annually, (due dates will be assigned by instructors). Students will not be allowed to participate in class, laboratory, or clinical until the annual requirements are completed.

1. A revised health history (Page 5)
2. A physical examination by a physician or certified nurse practitioner.....(Page 6)
3. Clinical Tests: A negative TB Skin Test, chest X-ray (with negative results recorded) or negative IGRA (QuantiFeron Gold or T-Spot)
4. Flu vaccine annually in the fall semester (due November 1). Students returning in the spring and summer semesters must show documentation of flu vaccine between Oct. 1 of the previous year and the beginning of the semester.

Biennial (every 2 years) Requirements:

Continuing and/or repeating nursing and allied health students' are required to complete the following biennially or every 2 years. Students will not be allowed to participate in class, laboratory, or clinical until the biennial requirements are completed.

1. CPR certification must be updated PRIOR to the start of the semester in which it expires, i.e., if CPR expires March, 2017, it must be updated prior to the start of the Spring 2017 semester.
2. Background Check must be updated PRIOR to the semester in which it expires, i.e., if Background check expires Sept 20, 2017, it must be updated prior to the start of the Fall 2017 semester.

Facts to Remember about All Immunizations:

1. If a student is pregnant or breast feeding, immunizations may be deferred with written documentation from a physician.
2. If immunizations cannot be taken, such as for allergies, written documentation must be provided by a physician.
3. The clinical agencies may reserve the right to deny the student clinical experiences based on their policies pertaining to no. 1 and 2.
4. MMR and TB skin test can be initiated on the same day but a 30 day waiting period is required if the TB is requested after the administration of the MMR.
5. There is a waiting period of at least 30 days between the two Varicella injections. There must be at least 14 days between the last injection and the first clinical day.

Please note HIPAA regulations prevent sending confidential information to an unsecured fax machine. Student information will need to be mailed or hand-delivered to the Clinical Records Clerk at the address provided above, on or before the deadline date.

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Health History

Name of Student: _____
 (Print) Last First Middle
 SS# or ID# _____ Date of Birth: _____
 Phone: _____ Cell Phone: _____
 Email: _____
 Current Address: _____ City _____ State/Zip _____
 Emergency Contact: _____ Phone: _____

1. Have you ever had or do you now have the following: (Please check at left of each item) If you check "Yes", please comment below about previous/current treatment.

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> <input type="checkbox"/> Tooth or Gum Problems	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Diphtheria	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Digestive Disturbances
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Hernia
<input type="checkbox"/> <input type="checkbox"/> Mumps or Measles	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Kidney or Bladder Problems
<input type="checkbox"/> <input type="checkbox"/> German Measles	<input type="checkbox"/> <input type="checkbox"/> Chronic Cough	<input type="checkbox"/> <input type="checkbox"/> Back Problems
<input type="checkbox"/> <input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> History of Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Menstrual Disorders	<input type="checkbox"/> <input type="checkbox"/> Foot Problems
<input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizure Disorders	<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Frequent Severe Headaches	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Speech Difficulties
<input type="checkbox"/> <input type="checkbox"/> Eye Problems	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Hearing Difficulties
<input type="checkbox"/> <input type="checkbox"/> Glasses/Contact Lenses	<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Skin Disorders
<input type="checkbox"/> <input type="checkbox"/> Ear/Nose/Throat Problems	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Hearing Aids	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Excessive Weight Loss

Comments: _____

- 2. Allergies (food, medication, latex, etc.) _____
- 3. Current Medications: _____
- 4. Drug or Alcohol Rehabilitation: _____
- 5. Surgical Operations: _____

- 6. Accidents or Injuries: _____
- 7. Other Health Problems: _____

I certify that I have reviewed the information recorded and that it is true and complete to the best of my knowledge.

Date: _____ Signed: _____

**Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Physical Exam Form**

Student Name: _____ SS#/ID#: _____ Program: _____ Campus: _____

To be completed by a physician or certified nurse practitioner

Vital Signs:		B/P _____	PR _____	Height _____	Weight _____
General Appearance	Neck / Head		Peripheral Vascular		
Eyes	Chest		Musculoskeletal		
Visual Acuity	Lungs		Neurological		
Ears	Heart		Skin		
Auditory Acuity	Abdomen				
Nose/Throat	Nutritional Status				

Current Treatment _____

Remarks / Special Recommendations _____

Print Physician's/Nurse Practitioner's Name _____

Print Physician's/Nurse Practitioner's Address _____

Physician's/Nurse Practitioner's Phone Number _____

<p>In your opinion, is there any health problem or prescribed medication which would interfere with this individual's ability to pursue a program of study that requires classroom and clinical experiences, including physical activity? ___ No ___ Yes (Explain) _____ _____ _____</p>	<p>Signed _____ Physician or Nurse Practitioner</p> <p>Date _____</p>
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