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
Rosie Jackson, Program Director, NAHC  
**Associate Degree Nursing**  
601-376-4860  
rajackson@hindssc.edu

Jane Skinner, Nursing Director, Vicksburg Campus  
**Associate Degree Nursing/Practical Nursing**  
601-629-6870  
mjskinner@hindssc.edu

Portia Travis, Program Director, Transition to RN  
**Associate Degree Nursing**  
1750 Chadwick Drive  
Jackson, MS 39204  
601-376-4862  
pftravis@hindssc.edu

Audrey Murray, Nursing Director, Rankin Campus  
**Associate Degree Nursing/Practical Nursing**  
601-936-1842  
ACMurray@hindssc.edu

Rebecca Cockrell,  
Learning Lab/Clinical Coordinator  
**Associate Degree Nursing/Practical Nursing**  
601-376-4903  
Rebecca.Cockrell@hindssc.edu

Valeria Winston, Program Chair  
**Dental Assisting**  
601-376-4820  
Valeria.Winston@hindssc.edu

Lesa Wilson, Program Chair  
**Diagnostic Medical Sonography**  
601-376-4821  
lbwilson@hindssc.edu

Brian Staley, Program Chair  
**Emergency Medical Technology**  
601-376-4822  
Brian.Staley@hindssc.edu

Elinda Hagan, Program Chair  
**Healthcare Assistant**  
601-376-4839  
Elinda.Hagan@hindssc.edu

Michele McGuffee, Program Chair  
**Health Information Technology**  
601-376-4823  
mlmcguffee@hindssc.edu

Chrissy Clark, Program Chair  
**Medical Assisting Technology**  
601-936-5582  
cmking@hindssc.edu

LaJuanda Portis, Program Chair  
**Medical Laboratory Technology**  
601-376-4824  
LaJuanda.Portis@hindssc.edu

Pam Chapman, Program Chair  
**Physical Therapist Assistant**  
601-376-4825  
pptchapman@hindssc.edu

Priscilla Burks,  
District Director of Practical Nursing  
**Practical Nursing**  
601-376-4850  
Priscilla.Burks@hindssc.edu

Steve Compton, Program Chair  
**Radiologic Technology**  
601-376-4826  
sccompton@hindssc.edu

Therese Winschel, Program Chair  
**Respiratory Care**  
601-376-4827  
TEWinschel@hindssc.edu

Dottie Binkley, Program Chair  
**Surgical Technology**  
601-376-4828  
ddbinkley@hindssc.edu

Kim Neely, Health  
Continuing Education Coordinator  
**Short-Term [Nursing Assistant & Phlebotomy]**  
**Reorientation to Nursing**  
601-376-4958  
Kimberly.Neely@hindssc.edu

Make a copy of your documents prior to submission; there will be a charge of $5.00 per page for any copy request.
Clinical Record Requirements

DO NOT TURN IN DOCUMENTATION WITHOUT MAKING A COPY!!

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Health History Upon Admission &amp; Annually Thereafter</td>
<td>To be completed by the student, Page 5.</td>
</tr>
<tr>
<td>Completed Physical Exam Form Upon Admission &amp; Annually Thereafter</td>
<td>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 been completed no earlier than May 1st. All areas must be completed on the Hinds Community College approved form on page 5.</td>
</tr>
<tr>
<td>*Tetanus, Diptheria, &amp; Pertussis</td>
<td>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)</td>
</tr>
<tr>
<td>*Varicella Titer or Copy of immunization record verifying proof of two Varicella immunizations</td>
<td>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.</td>
</tr>
<tr>
<td>*TB skin test, chest x-ray (CXR) or IGRA, Upon Admission &amp; Annually Thereafter</td>
<td>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.</td>
</tr>
<tr>
<td>*MMR (2)</td>
<td>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.</td>
</tr>
<tr>
<td>*Hepatitis B Immunization/Immunity</td>
<td>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).</td>
</tr>
<tr>
<td>*Flu Vaccine Annually between October 1 &amp; November 1</td>
<td>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.</td>
</tr>
<tr>
<td>CPR: Upon Admission and Every 2 Years Thereafter</td>
<td>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.</td>
</tr>
<tr>
<td>Background Records Check: Upon Admission and Every 2 Years Thereafter</td>
<td>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: <a href="http://www.hindscc.edu">http://www.hindscc.edu</a> (Programs of Study to Nursing and Health Related Programs to Nursing and Allied Health Student Manual)</td>
</tr>
</tbody>
</table>
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.
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.

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

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: ____________________________________________

For questions or information, contact Clinical Records Clerk at 601.376.4806

Make a copy of your documents prior to submission; there will be a charge of $5.00 per page for any copy request.
Physical Exam Form

Student Name: ____________________ SS#/ID#: ____________ Program: ____________ Campus: ________

To be completed by a physician or certified nurse practitioner

<table>
<thead>
<tr>
<th>Vital Signs:</th>
<th>B/P</th>
<th>PR</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>Neck / Head</td>
<td>Peripheral Vascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Chest</td>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Acuity</td>
<td>Lungs</td>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td>Heart</td>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditory Acuity</td>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose/Throat</td>
<td>Nutritional Status</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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)

Signed

Physician or Nurse Practitioner

Date

For questions or information, contact Clinical Records Clerk at 601.376.4806

Make a copy of your documents prior to submission; there will be a charge of $5.00 per page for any copy request.