



**CONSENT FOR RELEASE**

The purpose of this release is to provide documentation of drug screen results, immunizations, and background checks to clinical facilities that are part of the educational programs of the College.

**Drug Screen Results and Immunization Record**

My signature below hereby authorizes, without reservation, Cabarrus College of Health Sciences to release my immunization record and my drug screen results and any related information to agencies providing clinical experiences for my educational program as necessary in the normal course of business. In addition, I hereby waive any and all claims or causes of action that I may have against the College or any clinical affiliation sites, resulting from the release of such information. This authorization will expire at the completion of my educational program unless previously revoked.

**Consumer Reports (Background Check)**

In connection with my admission to Cabarrus College of Health Sciences, I understand that consumer or investigative consumer reports which may contain public record information, may be requested or made on me including criminal records, driving record, education, prior employer verification, workers compensation claims and others. Further I understand that you will be requesting information from various Federal, State and Local agencies regarding my past activities. I also understand that the information below regarding sex, race and date of birth is requested for the sole purpose of gathering the above information correctly, and will not be used to discriminate against me in violation of any law.

If negative information resulting in a change of my status with the College is contained in my report, I understand that I will be notified of such information by the Dean for Academic and Student Services. I understand that information contained in the criminal background report might result in the termination of my enrolled status. I also understand that any such termination may be appealed to the Dean for Academic and Student Services. I understand that I have a right to review the information that the College receives in this criminal background investigation by putting a request in writing, and that I may respond to the information. I understand that all reasonable efforts will be made by the College to protect the confidentiality of this information.

I hereby release those individuals or companies from any liability or damage in providing such information. I hereby further release the College and its agents and employees from any and all claims, including but not limited to claims of defamation, invasions of privacy, wrongful termination, negligence or any other damages of or resulting from or pertaining to the collection of this information. I understand I have the right to make a request of the Consumer Reporting Agency, upon proper identification and the payment of any authorized fees, the information in its files on me at the time of my request. I further authorize ongoing procurement of the above-mentioned reports at any time during my enrollment in the College.

My signature below hereby authorizes, without reservation, any party or agency to furnish the above-mentioned information and the College to share the results with agencies that provide clinical experiences related to my educational program as necessary in the normal course of business. This authorization will expire at the completion of my educational program unless previously revoked.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR IDENTIFICATION PURPOSES: PLEASE PRINT ALL INFORMATION CLEARLY**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Other Names; Maiden, Aliases, etc.: \_\_\_\_\_

Date of Birth: Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

**LIST ALL ADDRESSES FOR THE PAST TEN (10) YEARS STARTING WITH THE MOST CURRENT:**

	STREET	CITY	STATE	ZIP	DATES (MM/YYYY)	
					FROM	TO
1.						
2.						
3.						
4.						
5.						



**GENERIC DRUG SCREENING FORM**  
PLEASE PUT "CONFIDENTIAL" ON ENVELOPE

Donor Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Test Date:: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone # - Day: \_\_\_\_\_ Evening: \_\_\_\_\_

List any prescription or non-prescription drug use within the past 30 days:

DRUG/MEDICATION	REASON FOR USE	PRESCRIBING PHYSICIAN (if Prescription)

List any medical, surgical, or dental procedure within the past 30 days:

PROCEDURE	REASON FOR PROCEDURE	TREATING PHYSICIAN/DENTIST

By your signature below, you attest that you have been informed that if the results of your test are positive, you have the right under North Carolina law to have the specimen that is already in the testing laboratory sent to another testing laboratory at your expense.

Donor Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Do Not Write Below This Line**

\_\_\_\_\_ Negative \_\_\_\_\_ Positive (copy SYVA test card below)

Name of Agency Drug Screen: \_\_\_\_\_

Address: \_\_\_\_\_

Phone:: \_\_\_\_\_ Collector: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date \_\_\_\_\_

This form should be returned by the agency performing the drug screen in an envelope marked **confidential** to:

Cabarrus College of Health Sciences - 401 Medical Park Drive, Concord, NC 28025  
t. 704.403.1555 or 1556 – f. 704.403.2077



### IMMUNIZATION RECORD

IMMUNIZATION RECORD

LAST NAME			FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SS#
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Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. **Student to confirm identifying information above is complete before submission.**

**SECTION A – Required Immunizations**

	Doses	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* DTP or Td or Tdap <sup>1</sup>	3	(#1)	(#2)	(#3)	(#4)
* <b>Tdap booster (If due update after 7/2008)</b>					
* Td booster					
* Polio <sup>2</sup>	3				
* MMR ( after first birthday)					
* Measles/ Rubella (MR) (after first birthday)					
* Measles <sup>3</sup> (after first birthday)	2			** Disease Date	Titer Date & Result
* Mumps <sup>4</sup>	2			*** Disease Date <b>Not Acceptable</b>	Titer Date & Result
* Rubella <sup>5</sup>	1			*** Disease Date <b>Not Acceptable</b>	Titer Date & Result
* Hepatitis B <sup>6</sup> (required for all students enrolling in clinical programs)	3				**** Titer Date & Result

**Section B – Recommended Immunizations/Required for Students in Clinical Programs (all programs but HSLM & AS)**

		mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Hepatitis B series only <b>or</b>					**** Titer Date & Result
* Hepatitis A/B combination series					
* Varicella (chicken pox) series of two doses or Immunity by positive blood titer				Disease Date	**** Titer Date & Result
* Tuberculin Skin Test (PPD) (within 12 months) <b>Report Result in mm induration</b>	Date:				
	Read:				
* Chest X-ray, if positive PPD	Date:				
	Results:				
* Treatment if applicable	Date:				

**Section C – Optional Immunizations**

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Haemophilus influenzae type b				
* Pneumococcal				
* Hepatitis A series only				
* HPV (Gardasil)				
* Other				

Signature of Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_ Date \_\_\_\_\_

Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_



## IMMUNIZATION RECORD

\*\*Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

\*\*\*Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician is not acceptable.

\*\*\*\*Lab Report must be submitted.

**Footnote**<sup>1</sup> - DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which one must have been within the past 10 years.

Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid or tetanus/diphtheria/pertussis vaccine has not been administered within the past 10 years.

**Footnote**<sup>2</sup> - An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

**Footnote**<sup>3</sup> - Measles vaccines are not required if any of the following occur: Diagnoses of disease prior to January 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles; or An individual born prior to 1957. An individual who enrolled in college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.

**Footnote**<sup>4</sup> - Mumps vaccine is not required if any of the following occur: An individual who has been documented by serological testing to have a protective antibody titer against mumps; An individual born prior to 1957; or Enrolled in college or university for the first time before July 1, 1994. An individual entering college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.

**Footnote**<sup>5</sup> - Rubella vaccine is not required if any of the following occur: 50 years of age or older; Enrolled in college or university before February 1, 1989 and after their 30th birthday; An individual who has been documented by serological testing to have a protective antibody titer against rubella.

**Footnote**<sup>6</sup> - Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994.



## PHYSICAL AND EMOTIONAL HEALTH ASSESSMENT

### TO BE COMPLETED BY STUDENT

Last Name	First Name	Middle Name	Date Of Birth	SS#
Address		City	State & Zip	
Phone (Home)	Alternate Phone	Email		
<input type="checkbox"/> Associate of Science		<input type="checkbox"/> Medical Assistant	<input type="checkbox"/> Nursing (AND)	<input type="checkbox"/> Nursing (BSN)
<input type="checkbox"/> Surgical Technology		<input type="checkbox"/> Medical Imaging		
<input type="checkbox"/> Occupational Therapy Assistant		<input type="checkbox"/> Pharmacy Technology		
<input type="checkbox"/> Program		<input type="checkbox"/> Health Services Leadership & Management (HSLM)		
				Start Date (MM/YYYY)

### TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

*To be completed by healthcare provider: Please read the essential functions of the college that your patient is entering and answer the questions below based on your assessment.*

#### Essential Functions of the Cabarrus College of Health Sciences Degree and Diploma Students

1. Critical thinking ability sufficient for clinical and/or fieldwork judgment; ability to organize responsibilities, make decisions and analyze data or reports.
2. Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural and intellectual backgrounds.
3. Communication abilities sufficient for interaction with others in verbal and written form
4. Physical abilities sufficient to move from room to room and maneuver in small places, and stand, walk or sit for extensive periods of time.
5. Gross and fine motor abilities to provide safe and effective care. Full range body motion.
6. Auditory ability sufficient to monitor and assess health needs.
7. Visual ability sufficient for observation and assessment.
8. Tactile ability sufficient for physical assessment.
9. Physical ability to lift and manipulate and/or move 45-50 pounds daily.
10. Cognitive abilities with orientation to time, place and person, ability to focus on problems and prioritize average or above intellectual functioning.

	<b>To the Best of Your Knowledge:</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student able to perform the essential function identified above without reasonable accommodations?	If no, please explain. If reasonable accommodations are required please explain. Attach additional paper if necessary.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does this student have any disease or disorder of physical or emotional nature that could affect the safety of the client, fellow classmates, faculty, staff or himself/herself in the classroom, clinical or fieldwork setting?	If yes, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student now taking any prescribed medications?	If yes, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any additional physical or emotional factors, which you believe the college should be aware?	If yes, please explain:

**Please Print:**

Name of Healthcare Provider: \_\_\_\_\_ Title: \_\_\_\_\_

Practice/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Length of Time You Have Known the Student: \_\_\_\_\_

Relationship to Student:  Regular Healthcare Provider       Urgent Care Provider       Friend/Acquaintance       Other

Signature of Healthcare Provider \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_



## STATEMENT OF HEALTH INSURANCE

I have been presented information regarding my requirement and responsibility to have health insurance coverage while participating in the programs of study at Cabarrus College of Health Sciences. I understand the risks involved in working with patients/clients in clinical settings and medical and/or laboratory equipment.

My current health insurance provider: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
City State Zip

Insurance Company's Phone Number: \_\_\_\_\_

### Updating Records

The above information is accurate. In the event that I change health insurance programs or no longer carry health insurance, I understand it is my responsibility to notify the college office. I further understand that if I do not report any changes in my insurance status I may face disciplinary action up to and including termination from the program and/or college.

**Please attach a copy of your current insurance card. It is the student's responsibility to provide an updated copy of this card each year to the college office or when your provider information changes.**

\_\_\_\_\_  
Name – Please Print Program

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Witness Signature Date

**Attach copy of current insurance card.**