CABARRUS COLLEGE OF HEALTH SCIENCES
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 #: _____________ - ____________ - ______________ Drivers License #:___________________ State: ______________

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

Street City State Zip Dates (MM/YEAR)

1. ____________________ ____ From: _____________ To: ___________

2. ____________________ ____ From: _____________ To: ___________

3. ____________________ ____ From: _____________ To: ___________

4. ____________________ ____ From: _____________ To: ___________

5. ____________________ ____ From: _____________ To: ___________

401 Medical Park Drive, Concord, NC 28025
Phone (704) 403-1555 or 1556 Fax (704) 403-2077

GENERIC DRUG SCREENING FORM

PLEASE PUT "CONFIDENTIAL" ON ENVELOPE

Donor Name: ______________________________ SS#: ___________________

Test Date: ________________________________ DOB: __________________

Telephone Number 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
Telephone (704) 403-1555 or 1556 Fax (704) 403-2077

CABARRUS COLLEGE OF HEALTH SCIENCES
Immunization Record

IMMUNIZATION RECORD		
LAST NAME FIRST NAME MIDDLE NAME	**DATE OF BIRTH**	**SS#**

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 [1]	3	(#1)	(#2)	(#3)	(#4)
* **Tdap booster (If due update after 7/2008)**					
* Td booster					
* Polio [2]	3				
* MMR (after first birthday)					
* Measles/ Rubella (MR) (after first birthday)					
* Measles (after first birthday)[3]	2			**Disease Date	Titer Date & Result
*Mumps [4]	2			***Disease Date Not Acceptable	Titer Date & Result
* Rubella [5]	1			***Disease Date Not Acceptable	Titer Date & Result
*Hepatitis B [6] (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 & A.S.)

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Hepatitus B series only or				****Titer Date & Result
* Hepatitus 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) Date Read				
(within 12 months) **Report result in mm induration**				
Chest X-ray, if positive PPD Date				
Results				
Treatment if applicable Date				

IMMUNIZATION RECORD		
LAST NAME FIRST NAME MIDDLE NAME	**DATE OF BIRTH**	**SS#**

Section C Optional Immunizations	mo/day/year	mo/day/year	mo/day/year
* Haemophilus influenzae type b			
* Pneumococcal			
* Hepatitus A series only			
* HPV (Gardasil)			
* Other			

Signature or Clinic Stamp REQUIRED:

____

Signature of Physician/ Physician Assistant/Nurse Practitioner Date

____

Print Name of Physician/Physician Assistant/Nurse Practitioner Phone Number

____

Office Address City State Zip Code

**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 [1] - 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 [2] - An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

Footnote [3]- 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 [4]- 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 [5]- 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 [6]- Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994.

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CABARRUS COLLEGE OF HEALTH SCIENCES
Physical and Emotional Health Assessment

To Be Completed By Student		
Last Name First Name Middle Name	*Date of Birth (mo/day/year)*	*Social Security Number*
Address	*City*	*State/Zip*
Phone (home) Alternate Phone	*email*	
Program: Associate of Science Medical Assistant Nursing (A.D.N.) Nursing (BSN) Surgical Technology Medical Imaging Occupational Therapy Assistant Health Services Leadership & Management (HSLM)		*Start date (month/year)*

(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 form 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.

	To the best of your knowledge:	
☐ Yes ☐ 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.
☐ Yes ☐ 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:
☐ Yes ☐ No	Is the student now taking any prescribed medications?	If yes, please list:
☐ Yes ☐ 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 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.

\insurance\statement
Originated March 10, 2005
Revised 12/04/07, 07/15/08

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