STUDENT DATA SHEET
WCC EMS PROGRAM

Student Name:_____

Student Number: _____

Date of Birth: _____

Mailing Address: _____

_____

Phone Numbers: Home _____

Cell _____

E-mail address: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Additional Contact Information: _____

Wallace Community College

Drug Screen Policy Agreement

In preparation for participation in clinical/laboratory activities of health science programs or other programs/activities requiring drug screening as outlined in the Wallace Community College Substance Abuse Control Policy, I hereby consent to submit to a urinalysis and/or other tests as shall be determined by Wallace Community College for the purpose of determining substance use. I agree that specimens for the tests will be collected in accordance with guidelines established in the Mandatory Guidelines for Federal Workplace Drug Testing Programs and as described in the Wallace Community College Substance Abuse Control Policy Guidelines.

I further agree to, and hereby authorize, the release of the results of said tests to the appropriate designee of Wallace Community College. All positive results will be reviewed by said College designee and followed by a confidential contact with me.
I understand that positive results indicating the current use of drugs and/or alcohol shall prohibit me from participating in clinical, laboratory, or other activities of health science programs requiring that I be drug free. I further understand that clinical/laboratory components of courses within health programs are required curriculum components and that an inability to attend said components may prevent or delay my program completion. I also understand that while participating in clinical activities within outside healthcare agencies, I will be subject to the same rules as the health care employees in said facilities.

I agree to hold harmless Wallace Community College and its designee/s and PrimeCare and its Medical Review Officer from any liability arising in whole or in part from the collection of specimens, testing, and use of the results from said tests in connection with excluding me from participation in clinical/laboratory activities.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced by anyone to sign this document. A copy of this signed and dated document will constitute my consent for PrimeCare to perform the drug screen and to release the results to Wallace Community College.

_____

Signature

_____

Printed Name Student Number

_____

Date

WALLACE COMMUNITY COLLEGE

Background Screening Consent and Release Form

I have received and carefully read the Background Screening Policy for Students in the Health Sciences. I understand that compliance with the background screening policy is a requirement to complete my admission to and/or maintain enrollment in a health care program at Wallace Community College.

By signing this document, I am indicating that I have read and understand Wallace Community College's Background Screening Policy for Students in the Health Sciences. My signature also indicates my agreement to complete the requirement and to submit required information to the approved screening vendor. I understand that my enrollment in health program courses is conditional to the provision of negative findings or facility approval upon circumstantial review. In the event of positive findings on my background screen and follow-up denial of access to or declared ineligibility to continue in clinical learning experiences, further attendance in health program courses will not be allowed. I will be offered the opportunity to withdraw from all courses in my health program for which I am enrolled. My failure to withdraw as directed will result in the assignment of the appropriate course grade, whether NA, CA, or WF.

A copy of this signed and dated document will constitute my consent to abide by the College's Background Screening Policy. Upon submission of my personal information to the approved screening vendor, I also consent to approve the release of the original screening results to the approved College designee. A copy of this signed and dated document, along with approval during the information submission process, will constitute my consent for the College to release the results of my background screen to the clinical affiliate(s)' specifically designated person(s). I agree to hold harmless the College and its officers, agents, and employees from and against any harm, claim, suit, or cause of action, which may occur as a direct or indirect result of the background screen or release of the results to the College and/or the clinical affiliates. I understand that should any legal action be taken as a result of the background screen, that confidentiality can no longer be maintained.

I agree to abide by the aforementioned policy. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document. I hereby acknowledge that I will authorize the College's contracted agents to procure a background screen on me. I further understand this signed consent hereby authorizes the College's contracted agents to conduct necessary and/or periodic background screens and/or updates as required by contractual agreements with clinical affiliates.

_____	_____
Student Signature	Witness Signature
_____	_____
Student's Printed Name	Witness' Printed Name
_____	_____
Date	Date

WALLACE COMMUNITY COLLEGE
EMERGENCY MEDICAL SERVICES

PARTICIPATION DISCLAIMER

I understand that as a student in the Emergency Medical Services Program that I will participate in activities that will require me to act as a patient, as well as, a health care provider. These activities include, but are not limited to, patient assessment, splinting, and spine stabilization. The process of assessing and treating patients/classmates may require observation and touching of the body. I understand that it is my responsibility to demonstrate professionalism at all times and to know the correct application procedures for the devices used in the EMS field. I further understand that I must give prior notification to the instructor if I have a valid reason not to participate in any activity. It is important for all students to recognize that any form of harassment will not be tolerated and will be handled in accordance with Wallace Community College policy as listed in the college catalog. I agree to participate in class, clinical and lab activities and will conduct myself in a professional manner at all times. With this knowledge, I release Wallace Community College and its instructors from any claims that might arise from my participation.

_____
Signature

_____
Printed Name

_____
Date

Wallace Community College
Emergency Medical Services Program
EMS Liability Release Form

I, _____, hereby acknowledge that I am eighteen years of age or older. I further acknowledge that I fully understand the contents of this release and that I am signing it voluntarily.

As a student of the Emergency Medical Services Program at Wallace Community College, I am aware of the risk of personal injury, illness or death which is inherent in my participating in EMS classroom, laboratory, clinical and field internship activities. I understand that medical insurance and responsibility for payment of medical bills incurred during the program are my responsibility. I further understand that I am responsible for all vaccinations, including hepatitis B, that are required for program admission.

Upon full awareness and consideration of the risks which I might assume in participating in classroom, laboratory, clinical or field internship activities, I hereby agree to release Wallace Community College and its instructors, officials, agents, representatives, clinical sites, and employees from any liability for any type of illness or injury which is incurred to me during my participation in the program. This release will remain in effect for the duration of my enrollment in the Emergency Medical Services Program.

_____
Student Signature / Date

_____
Witness Signature / Date

HSRC Course

Clinical Training

You will find the HSRC Course in your Blackboard account.

Once you have passed the training, print final scores and include in this packet.

WALLACE COMMUNITY COLLEGE
EMERGENCY MEDICAL SERVICES
RELEASE OF CLINICAL INFORMATION

I give Wallace Community College permission to release copies of my personal clinical/program documentation to clinical agencies as required by contractual agreements. These records will only be released to Human Resources or such centrally governed departments and include, **but are NOT limited to**: immunizations, TB skin tests, titer results, CPR, substance abuse screens, background checks, essential functions/physician's statement, and clinical agency training acknowledgements and verifications.

_____ _____
Student Name (Print) Department (WCC Health Program)

_____ _____
Signature WCC Student ID #

_____
Date

WALLACE COMMUNITY COLLEGE
Emergency Medical Services

WAIVER OF RESPONSIBILITY

I,_____(print name), a student in the ***Emergency Medical Services*** at Wallace Community College, accept all responsibilities for accident/illness/injury sustained in or related to the performance of normal class/lab/clinical activities. Therefore, I hold the College/clinical agency harmless should accident/illness/injury occur.

_____ _____
Student Signature Date

_____
Student ID#

EMERGENCY MEDICAL SERVICES PROGRAM
HEALTH INSURANCE FORM

It is recommended that all students in the EMS Program have health insurance. You MUST complete the applicable portion of this form prior to any clinical or learning lab experience. If you do not have health insurance, you are required to sign a waiver that will remain in the EMS Program files.

Name of Insurance Company _____

_____
Student's Signature

_____
Date

WAIVER:

I, _____, have been informed and understand the importance
(Name of Student)
of obtaining health insurance. I am currently not covered by personal health insurance and elect not to obtain any health insurance at this time. I understand that it is my responsibility to pay for all medical expenses that result from illness or injury that may occur while I am a student in the EMS Program.

I release Wallace Community College and/or its agents, and any and all affiliate clinical facilities and/or their agents from any liability related to injuries or illness received while a student in the EMS Program.

_____
Student's Signature

_____
Date

Include a copy of valid Driver's License

(Copiers available in Resource Center)

EMERGENCY MEDICAL SERVICES

HEALTH RECORDS POLICY

Validation and documentation of required health records must be received by all students enrolled in an allied health program. **Students who fail to submit required records will not be allowed to continue in the program.** *If you have questions concerning this process, contact Shannon McNabb at 334-556-2388.*

All students are required to have a physical examination at the student's expense. The physical examination / health requirements protect the student by identifying any potential or real health problems that may be exacerbated by the demands of the clinical portion of the program.

Health professions are strenuous, both physically and psychologically. The student's ability to handle these demands must be established. It is also imperative that students do not expose clients or agency personnel to communicable disease, or risk their safety due to the inability to handle the physical or psychological stress of client care.

***NOTE*:** Updates to health records such as TB or CPR may be required while a student is enrolled in the program. **Any updates will be due at the beginning of the semester in which they expire.** *For example*, a TB skin test is required annually. If it expires in March of the spring semester, the update will be due no later than the first week of class, in January.

The following are required for ALL students:

1. PHYSICAL EXAMINATION – A **physical examination**, completed within the past year, is required for all new students. The physical must be signed by a licensed physician or nurse practitioner. The examination must be documented on the Program's **Health Record and Essential Functions Form** as required by The Alabama Community College System. New students and any student returning to an allied health program after an absence of one (1) year must submit current completed health forms.

2. IMMUNIZATIONS / TITERS – It is the STUDENT'S RESPONSIBILITY to keep all health records current. **Documentation of any required updates should be submitted to the allied health secretary as soon as possible.** The following are required:

   Tetanus (Tdap) Vaccine

   Students entering an allied health program must provide documentation of an ***adult*** **Tdap vaccine** (tetanus, diphtheria, and pertussis). If the documented Tdap vaccine is over ten (10) years old, documentation of a Td (tetanus and diphtheria) or Tdap booster that is less than ten (10) years old is also required. An update is required every ten (10) years.

   TB Skin Test

   A **two-step** TB Skin Test is required at the beginning of the program. This consists of one test followed by a second test 7-21 days later. The results cannot be more than four (4) weeks apart.

   Documentation of a TB blood test (TB Gold) may be provided in lieu of TB skin test. An annual blood test or one-step TB skin test will be required thereafter.

   An annual one-step TB Skin Test is required each following year and is YOUR RESPONSIBILITY to provide to the allied health secretary when due. Student will be unable to complete clinical site training if he or she fails to submit to results of annual TB screening.

If you have had a positive TB result, submit proof of that result as well as proof of a clear chest x-ray. Documentation of reason for chest x-ray instead of serum is required.

MMRV Titer

A MMRV - Measles, Mumps, Rubella (German Measles), and Varicella (Chicken Pox) titer is required to enter an allied health program. If any results are negative or non-immune, the student must sign the *MMRV Waiver Form* and submit it with the negative or non-immune results. The student is advised to consult with a physician regarding precautions to prevent infection.

Hepatitis B

A Hepatitis B titer is required to enter an allied health program. If the results are negative or non-immune, the student must sign the *Hepatitis B Waiver Form* to be submitted with these results. The student is advised to consult with a physician regarding precautions to prevent infection. Results must be within the past twenty (20) years.

3. CONTINUING HEALTH STATUS – It is a STUDENT'S RESPONSIBILITY to notify the program faculty of any changes in his/her health status, i.e. pregnancy, surgery, injuries, etc. Additional examinations from a health care provider, with documentation of results, may be required by an instructor for any changes in a student's health status.

4. PROFESSIONAL LIABILITY INSURANCE – Students in an allied health program are required to purchase professional liability insurance (malpractice insurance) through the College, each semester they enroll in an allied health course. This fee is added to your course registration as **NUR000** and is to be paid at registration each applicable semester.

5. HEALTH INSURANCE – Wallace Community College and the allied health programs do not provide health insurance coverage for students. Students are responsible for costs incurred as a result of an accident/injury in the clinical or college laboratory. This may include follow-up testing and/or treatment mandated by the program/clinical agency. Students are not entitled to any Workmen's Compensation benefits from agencies. Health insurance coverage is strongly recommended.

Wallace Community College – Emergency Medical Services

STUDENT INFORMATION / CHECKLIST

Before beginning any EMS Program course, you must submit proof of the following items. NO exceptions can or will be made regarding submission of documentation by a medical professional. Turn in all health record documentation to EMS Program Personnel on the Wallace Campus in Dothan by the required deadline.

Student Name: _____ Student ID Number: _____

ITEM	DOCUMENTATION REQUIRED	☑
Essential Functions / Physician's Statement	The *Essential Functions / Physician's Statement Form* must be signed by the student and signed by a **physician, physician's assistant, or a nurse practitioner.** ***Attach completed form.***	
Health Record Form	The *Health Record Form* must be completed and signed by a **physician, physician's assistant, or a nurse practitioner.** ***Attach completed form.***	
Tetanus (Tdap) Vaccine	Documentation of an ***adult*** Tdap vaccine. Any Tdap older than ten (10) years must also be followed by documentation of a Tetanus booster (Td or Tdap) that is less than ten (10) years old. ***Attach medical documentation.***	
PPD or Tuberculosis (TB Skin Test)	Documentation of a *two-step* TB skin test, consisting of one test followed by a *second test 7-21 days later*. *The results cannot be more than four (4) weeks apart*. TB skin tests are good for a period of one (1) year from the administration date. An annual one-step TB skin test will be required thereafter. ***Attach medical documentation.*** **OR** Documentation of a TB blood test (TB Gold). An annual blood test or one-step TB Skin Test will be required thereafter. **Attach medical documentation.** **OR** Documentation of a clear **chest x-ray** will be accepted for students who are unable to receive the TB skin test due to a positive TB result or previous BCG vaccination. Completion of an annual *Tuberculosis Questionnaire* will also be required. **Attach medical documentation.**	
MMRV Titers	Documentation of **titer** results for MMRV – Measles (Rubeola), Mumps, Rubella (German Measles), and Varicella (Chicken Pox). If results are non-immune (negative) or equivocal, the student is instructed to seek the advice of a medical provider for recommended follow-up and must sign a *Measles, Mumps, Rubella, Varicella Release / Waiver Form*. ***Attach lab data report.***	
Hepatitis B Titer	Documentation of **titer** results for Hepatitis B. Results must be within the past twenty (20) years. If results are non-immune (negative), the student is instructed to seek the advice of a medical provider for recommended follow-up and must sign a *Hepatitis B Vaccination Release / Waiver Form*. **Attach lab data report.**	
CPR *EMS Basic includes CPR training within the program.*	Documentation of current CPR certification by the American Heart Association Basic Life Support (BLS) for Health Care Providers (CPR/AED) or American Red Cross CPR for Professional Rescuer. **Attach a copy of card / certificate**	
Release Form	Read and sign the *Release of Clinical Information* form. **Attach completed form.**	

IMPORTANT: **All documentation must be legible. Copies will not be made for you by Program personnel.** It is a student's responsibility to maintain a personal file with all health records. Once submitted to the EMS Program Office, no records will be released back to students. There is a student copier available in the Learning Resource Center.

It is the student's responsibility to contact Allied Health Secretary regarding signing up for an appointment time to submit records.

Wallace Community College – Emergency Medical Services
HEALTH RECORD FORM

Name:_____ **Student ID #:**_____
(Please Print)
Address:_____ **Contact Number:**_____

Emergency Contact Person:_____ **Contact Number:**_____

INSTRUCTIONS: A physician, nurse practitioner, or physician's assistant must complete and sign this form. Attach copies of lab results documenting Tdap vaccination (and booster if applicable), TB skin test, or TB blood test and/or chest x-ray, and MMRV and Hepatitis B titer results when submitting this form to EMS Program personnel or Program Secretary. If TB chest x-ray is required, documentation of reason for chest x-ray instead of serum is required.

Requirements	
Tetanus Vaccine (tetanus, diphtheria, pertussis) *All students must have a documented Tdap vaccine.*	**Date Administered:** ____ - ____ - ____
Td or Tdap Booster *Only applicable if above Tdap vaccine is older than ten (10) years. Adult Tdap must be followed by Td booster every ten years thereafter.*	**Date Administered:** ____ - ____ - ____ **OR** **Not Applicable** _____ (physician's initials)
MMRV Titers ***Titer results are required***. Vaccination records will not be accepted in place of titer results	**Date(s) Drawn / Results:** **Measles** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal **Mumps** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal **Rubella** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal **Varicella** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal
Hepatitis B Titer ***Titer results are required***. *Vaccination records* will not *be accepted in place of titer results.*	**Date Drawn / Results:** ____ - ____ - ____ / □ Immune □ Not Immune
2-step TB Skin Test **or Chest X-ray** *Results from the two-step TB skin tests* ***cannot be more than four (4) weeks apart***. *Results are valid for one year. A one-step TB update will be required thereafter.* *A TB blood test may be used in place of a two-step TB skin test.* ***Students who have tested positive for TB or who are unable to receive the TB skin test must submit narrative documentation of a clear chest x-ray. Documentation of reason for chest x-ray instead of serum is required.***	**1st Step** Lot # _____ Manuf. _____ Exp. Date _____ Time Applied _____ Reader Signature _____ Date Administered: ____ - ____ - ____ Date Read: ____ - ____ - ____ Result: _____ mm of induration Interpretation: □ Positive □ Negative **2nd Step** Lot # _____ Manuf. _____ Exp. Date _____ Time Applied _____ Reader Signature _____ Date Administered: ____ - ____ - ____ Date Read: ____ - ____ - ____ Result: _____ mm of induration Interpretation: □ Positive □ Negative **OR**_____ **TB Blood Test – Date Drawn / Results** **____ - ____ - ____/ □ Postitive □ Negative Type of Test: _____** **OR**_____ **Chest X-Ray** Date of CXR: ____ - ____ - ____ / Result: □ Normal □ Abnormal

Healthcare Provider Signature Required: I have reviewed this student's immunization status and have made recommendations regarding any follow-up related to safe practice as a health care provider.

_____
Physician, PA, or NP (Signature) Date Contact Number

_____
Physician, PA, or NP (Printed) Address

ESSENTIAL FUNCTIONS FORM
Wallace Community College

Emergency Medical Services

The Alabama Community College System endorses the Americans' with Disabilities Act. In accordance with College policy, when requested, reasonable accommodations may be provided for individuals with disabilities.

Physical, cognitive, psychomotor, affective and social abilities are required in unique combinations to provide safe and effective emergency medical care. The applicant/student must be able to meet the essential functions with or without reasonable accommodations throughout the program of learning. Admission, progression and graduation are contingent upon one's ability to demonstrate the essential functions delineated for the emergency medical services program with or without reasonable accommodations. The emergency medical services program and/or its affiliated clinical agencies may identify additional essential functions. The emergency medical services program reserves the right to amend the essential functions as deemed necessary.

In order to be admitted and to progress in the emergency medical services program one must possess a functional level of ability to perform the duties required of an EMT. Admission or progression may be denied if a student is unable to demonstrate the essential functions with or without reasonable accommodations.

The essential functions delineated are those deemed necessary for the emergency medical services program. No representation regarding industrial standards is implied. Similarly, any reasonable accommodations provided will be determined and applied to the respective emergency medical services program and may vary from reasonable accommodations made by healthcare employers.

The following essential functions delineated are necessary for emergency medical services program admission, progression and graduation and for the provision of safe and effective emergency medical services care.

EMERGENCY MEDICAL SERVICES
Program Essential Functions

Due to the requirements of the State of Alabama for EMS Licensure, no student will be admitted to any Wallace Community College Emergency Medical Services course who cannot meet the essential functions. The EMS student must:

1. have the physical agility to walk, climb, crawl, bend, push, pull, or lift and balance over less than ideal terrain;
2. have good physical stamina, endurance, which would not be adversely affected by having to lift, carry, and balance at times, in excess of 125 pounds (250 pounds with assistance);
3. see different color spectrums;
4. have good eye-hand coordination and manual dexterity to manipulate equipment, instrumentation and medications;
5. be able to send and receive verbal messages as well as operate appropriately the communication equipment of current technology;
6. be able to collect facts and to organize data accurately, to communicate clearly both orally and in writing in the English language (at the ninth grade reading level or higher);
7. be able to make good judgment decisions and exhibit problem solving skills under stressful situations;
8. be attentive to detail and be aware of standards and rules that govern practice;
10 implement therapies based upon mathematical calculation (at the ninth grade level or higher);
11. possess emotional stability to be able to perform duties in life-or-death situations and in potentially dangerous social situations, including responding to calls in districts known to have high crime rates;
12. be able to handle stress and work well as part of a team;
13. be oriented to reality and not be mentally impaired by mind altering substances;
14. not be addicted to drugs or alcohol;
15. be able to work shifts of 24 hours in length;
16. be able to tolerate being exposed to extremes in the environment including variable aspects of weather, hazardous fumes, and noise; and
17. possess eyesight in a minimum of one eye correctable to 20/20 vision and be able to determine directions, according to a map; and students who desire to drive an ambulance must possess approximately 180 degrees peripheral vision capacity, must possess a valid Alabama driver's license (if a resident of another state is employed in Alabama); and must be able to safely and competently operate a motor vehicle in accordance with state law.

Wallace Community College
Emergency Medical Services

HEALTH RECORD AND
STATEMENT OF ESSENTIAL FUNCTIONS
SIGNATURE PAGE

STUDENT STATEMENT

I have reviewed the Essential Functions for this program and I certify that to the best of my knowledge, I have the ability to perform these functions. I understand that a further evaluation of my abilities may be required and conducted by the Emergency Medical Services faculty, if deemed necessary, to evaluate my ability prior to admission to the program and for retention and progression through the program.

_____

Student Signature Date

_____

Student's Name (Printed)

PHYSICIAN STATEMENT

Based upon my assessment and evaluation, this person's mental and physical health

is _____ **is not** _____

sufficient to perform the classroom, laboratory, and clinical duties of an Emergency Medical Services student.

If person is not mentally or physically sufficient to perform, please explain. (Attach additional sheet if necessary)

_____

Physician, PA, or Nurse Practitioner (Signature) Date Contact Number

_____

Physician, PA, or Nurse Practitioner (Printed) Address

Effective 3/2020

WALLACE COMMUNITY COLLEGE
HEALTH SCIENCES
2020-2021

Flu Vaccine Info-- Students and Instructors

Print Name**:** _____

In order to document clinical attendance during the reported flu season of **October 1, 2020 – March 31, 2021**, Health Sciences students are required to respond to the following items.

Please note: Healthcare facilities may have requirements specific to their implementation of guidelines. For example, policy may prohibit patient care inside their facility for those who have not taken a current flu vaccine, or require wearing of a mask for persons granted exceptions.

Please check the following items that apply:

Are you an employee of a healthcare facility?

_____ **No**

_____ **Yes If yes, which facility?** _____

_____ **Yes,** I have received the flu vaccine. **Documentation required.**

_____ **No**, I do not wish to have the flu vaccine given to me. **If assigned to a facility which requires vaccination of all caregivers, you may not be allowed to complete clinical unless granted an exception. If granted an exception by the facility, you will be required to wear a mask during your clinical rotation (You may take the mask off while eating or going to the bathroom)**

_____ I am **not able** to receive the flu vaccine due to medical reasons:

_____ Severe allergic reaction to eggs or other components of the flu vaccine
_____ A history of Guillain-Barr'e syndrome within six weeks after a previous flu vaccination
_____Other:_____

I **do not wish** to receive the flu vaccines for the following reason:

Please check all that apply:

_____ Fear of side effects _____ Fear of getting the flu _____ Religious objection

_____ Fear of injections _____ Just do not want to _____ Other reasons

Aggregate data will be reported to the Centers for Medicare and Medicaid Services (CMS) & the CDC.

Signature: _____ Date: _____

WALLACE COMMUNITY COLLEGE
FLU Vaccination Receipt
2020-2021

Name: _____
(Please Print)

Student/Instructor ID#: _____

Vaccination Date: _____

Lot #: _____ Expiration date: _____ Site: L R Deltoid

Office Providing Vaccine: _____

Person Administering Flu Vaccination: _____
(Please Print)

_____
(Signature)