STUDENT CONFIDENTIALITY STATEMENT

I understand that it is the responsibility of each student to protect, preserve, and maintain the confidentiality of any and all patient information. Patients have the legal right to expect all of their medical and any other information to be handled in a confidential manner at all times.

PATIENT INFORMATION (your initials here) _____

The discussion or narration of any patient information of a personal nature, medical or otherwise, is strictly prohibited, except as required in the regular course of study. Such conversations, therefore, shall not take place in any public or semi-public area such as cafeterias, elevators, lobbies, etc. Such conversations shall be held in a professional manner, only as appropriate and necessary to provide patient care.

Patient identifiable information obtained through the course of study may not be used or disclosed in any form. Any reference to the identity of the patient will not be included in any case presentation, journal, notes, or any other educational activities. Patient identifiers include: patient name, address, telephone or fax numbers, medical record number, account number, social security number, health plan number, birth date, name of relatives or employers, photographic images or any other information that could be combined to identify the subject of the health information.

No student shall disclose information that by policy is not available to the public and/or that is acquired in the course of his/her studies with Hawaii Pacific University College of Health and Society or use such information for his/her personal gain or for the benefit of another, such as another student, a friend, spouse or relative.

STUDENT INFORMATION (your initials here) _____

I authorize Hawaii Pacific University College of Health and Society to provide my health/immunization record information to the appropriate department(s) at the facility(ies) where my clinical course(s) will be meeting. This authorization is in effect for the duration of my nursing studies or until revoked by me in writing.

FAILURE TO MAINTAIN CONFIDENTIALITY (your initials here) _____

I understand that any violation of these health care and business ethics shall constitute grounds for disciplinary action, up to and including dismissal from the nursing major and could result in civil or criminal liability.

I acknowledge, understand, and agree to abide by the foregoing.

Printed Name of Student _____ Date _____

_____
Signature of Student

_____
Signature of Witness

College of Health and Society
45-045 Kamehameha Highway
Kāne'ohe, HI 96744
USA

T: +1.808.236.3552
F: +1.808.236.3524

Founded in 1965, Hawai'i Pacific University (HPU) has grown to become the state's leading private, not-for-profit university with three campuses, presences on six military bases, and online courses offered to students around the world. HPU maintains strong academic programs, small class sizes, and a diverse faculty and student population.

With students from all 50 U.S. states and more than 80 countries, HPU is a leading destination for foreign students studying abroad and is recognized as one of America's top 20 masters universities in international enrollment.

HPU is accredited by the Accrediting Commission for Senior Colleges and Universities of the Western Association of Schools and Colleges (WASC), and has additional accreditations and memberships from nationally recognized groups.

www.hpu.edu

Declaration of Fitness/Criminal Background Check

A growing number of clinical and community facilities in Hawaii require a criminal background check of nursing students and faculty who are training or providing training in their facilities. The clinical and community facilities have the option to refuse training and provision of training access to any person who has been convicted of a penal offense substantially related to the qualifications, functions, or duties of a nurse.

The clinical and community facilities require verification through law enforcement agencies, information on offenses including felony and misdemeanor or violations for which incarceration is a sentencing option. Verification includes conducting Hawaii County and State and/or the United States Federal Bureau of Investigation criminal history check.

In addition, State Boards of Nursing throughout the United States have varying requirements concerning licensing nurses, including, among other things, requiring criminal background checks. In Hawaii, the particular statute is Hawaii Revised Statues Section 457-12.

Individuals with concerns in any of these areas are encouraged to contact the specific clinical and community facility and or the nurse-licensing agency regarding the likelihood of problems with placement in the clinical and or community agency or obtaining a nursing license.

Your signature on this Declaration of Fitness is verification that you were notified of these legal requirements with the clinical and community agencies and facilities of Hawaii. It is also an acknowledgement that you were notified that the right to sit for or seek nursing licensure is not guaranteed if you are unable to meet all of the requirements of the State Board of Nursing where you plan or find yourself needing to seek nursing licensure. Signing this Declaration of Fitness does not disqualify you for being admitted into the College of Health and Society. However, failure to sign and complete this statement disqualifies you from training in Hawaii's clinical and community agencies and facilities.

Date: _____ _____

Signature

_____

Print Name

_____

Student ID Number

Sept. 2006

College of Health and Society

45-045 Kamehameha Highway
Kāne'ohe, HI 96744
USA

T: +1.808.236.3552
F: +1.808.236.3524

STUDENT/FACULTY INFLUENZA VACCINE 2015-2016

PRINT Name:	Date:

Hawai'i Pacific University has mandated that I receive the influenza vaccination due to new facility requirements.

□ Received 2015-2016 <u>*inactivated*</u> influenza vaccine	Provider Information: _____ Date: _____
□ Received 2015-2016 <u>*activated*</u> influenza vaccine	Provider Information: _____ Date: _____
□ Will be receiving when the flu vaccine is available	
□ *Medical contraindications (systemic allergic reaction to ingredients, Guillain-Barre syndrome, etc.)*	Medical Contraindication: _____ Provider Signature: _____

_____ _____

Student Signature Date

College of Health and Society
45-045 Kamehameha Highway
Kāne'ohe, HI 96744
USA

T: +1.808.236.3552
F: +1.808.236.3524

Founded in 1965, Hawai'i Pacific University (HPU) has grown to become the state's leading private, not-for-profit university with three campuses, presences on six military bases, and online courses offered to students around the world. HPU maintains strong academic programs, small class sizes, and a diverse faculty and student population.

With students from all 50 U.S. states and more than 80 countries, HPU is a leading destination for foreign students studying abroad and is recognized as one of America's top 20 masters universities in international enrollment.

HPU is accredited by the Accrediting Commission for Senior Colleges and Universities of the Western Association of Schools and Colleges (WASC), and has additional accreditations and memberships from nationally recognized groups.

www.hpu.edu

Physical Examination Form (3 pages)

to be completed within 1 year of entry or upon request of the Dean

Name: _____ HPU ID Number: _____

Immunization Record and Health Report to be signed or stamped by health care provider.
Information written on this report is <u>NOT</u> proof of immunization or labs.

Immunizations/Screens
1. Mumps Screen: • <u>Positive screen/titer is required.</u> (Attach copy of lab result) If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
2. Rubeola Screen: • <u>Positive screen/titer is required.</u> (Attach copy of lab result) If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
3. Rubella Screen: • <u>Positive screen/titer is required.</u> (Attach copy of lab result) If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
4. Varicella/Chickenpox Screen (Vz): • <u>Positive screen/titer is required.</u> (Attach copy of lab result) If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
5. Hepatitis B Screen (HbsAb): • <u>Positive screen/titer is required.</u> (Attach copy of lab result) If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
6. Tdap (Tetanus/Diphtheria/acellular Pertussis) – NOTE: effective Fall 2014 Tdap is required for ALL students: • Immunization within the last 10 years is required • *For adults: Those who did not get the Tdap should get one dose as a booster. Most pregnant women not previously vaccinated with Tdap should get a dose before leaving the hospital. (Source: U.S. Centers for Disease Control and Prevention)*
7. Tuberculosis (TB/Mantoux/PPD): <u>Last two annual TB tests OR two-step TB test required</u> • 2 annual TB tests: Tests must be less than 1 year apart and must be less than a year old. • Two-step TB tests: Two TB tests within a two-week time period, the second one administered a week after the first one is read. • Positive TB test: Positive TB test and results AND x-ray report/card with clear or negative findings. X-ray must be less than 1 year old.

Student Signature: _____ Date: _____
Student's Signature is acknowledgement that they understand the requirements of immunizations.

Health Care Provider Signature: _____ Date: _____

College of Health and Society
45-045 Kamehameha Highway
Kāne'ohe, HI 96744
USA

T: +1.808.236.3552
F: +1.808.236.3524

Health Questionnaire: To be completed by Student prior to Physical Examination

_____ Yes _____ No	Do you have any physical limitations that would affect your ability to lift, turn, or transfer patients?
_____ Yes _____ No	Do you have any limitations in use of your senses, such as in sight, hearing, which would limit your ability to practice a health profession?
_____ Yes _____ No	Do you have any other condition that might interfere with your ability to practice in the health care profession?

If you answered "yes" to any of the above, please explain your limitations in detail, including any medications you take on a regular basis in the past year (attach a separate sheet of paper if necessary):

_____

_____

_____

_____

_____

_____

_____

History: Include any significant information regarding previous medical/surgical or psychiatric conditions and use of alcohol or drugs:

_____

_____

_____

_____

_____

_____

_____

Student Signature: _____ Date: _____

Health Care Provider's Certification of Fitness:
PHYSICAL EXAMINATION FORM

- Students will be examined for evidence of being able to meet the physical requirements necessary for a nursing student:
  - Ability to stand, sit, kneel, bend, push, pull, carry, walk, reach, and twist
  - Manual dexterity to perform fine motor tasks needed for essential nursing tasks and use of equipment.
  - Ability to see, hear, and feel.
  - Ability to lift at least 50 pounds (essential to assist clients with ambulation, transfers, positon changes, transport).

Any comments r/t history provided: _____

_____

Gender: _____ Age: _____ Height: _____ Weight: _____

Blood pressure: _____ Pulse: _____

Build: Slender _____ Medium _____ Heavy _____ Obese _____

Color vision: _____ Vision: OD 20/_____ OS 20/_____ Corr-to 20/_____

Normal		Abnormal	Details of Abnormality
	Head, neck, face, & scalp		
	Eyes, ears, nose		
	Mouth, teeth, gingiva, & throat		
	Thyroid		
	Lungs		
	Heart & vascular		
	Abdomen & viscera		
	Hernia		
	Neck, back, & spine		
	Upper extremities		
	Lower extremities		
	Other musculoskeletal		
	Skin and lymphatics		
	Neurologic		
	Psychiatric (specify deviations noted)		

Lab Data (if indicated): Hgb: _____ WBC: _____ Urinalysis (dipstick): _____

I have examined _____ and have found her/him to be free from any impairments or restrictions that may impede functioning in a health care role.

Comments: _____

_____

_____ _____

Signature of Health Care Provider and License Number Printed name of Stamp of Health Care Provider

Address: _____

To all Nursing Students Attending Hawaii Pacific Health clinical facilities

I give permission to provide the last four numbers of my social security number to any facilities requiring them for clinical placement and identification purposes.

Last Four Digits of your Social Security Number __ __ __ __

HPU ID Number: @ __ __ __ __ __ __ __ __

Name (Print): _____

Signature: _____

Date: _____

College of Health and Society
45-045 Kamehameha Highway
Kāne'ohe, HI 96744
USA

T: +1.808.236.3552
F: +1.808.236.3524

Founded in 1965, Hawai'i Pacific University (HPU) has grown to become the state's leading private, not-for-profit university with three campuses, presences on six military bases, and online courses offered to students around the world. HPU maintains strong academic programs, small class sizes, and a diverse faculty and student population.

With students from all 50 U.S. states and more than 80 countries, HPU is a leading destination for foreign students studying abroad and is recognized as one of America's top 20 masters universities in international enrollment.

HPU is accredited by the Accrediting Commission for Senior Colleges and Universities of the Western Association of Schools and Colleges (WASC), and has additional accreditations and memberships from nationally recognized groups.

www.hpu.edu

Tuberculosis Monitoring Questionnaire

HPU's affiliation agreements with the various health care agencies require that we monitor TB status of nursing students on an annual basis. Individuals with a **previous history of a positive PPD**, followed by a negative chest x-ray, are requested to provide ongoing TB monitoring by filling out this questionnaire to monitor for symptoms of tuberculosis.

Please check "yes" or "no" in the appropriate box. This form will be reviewed by the Health Records Assistant and you will be contacted if further follow up is required.

Have you experienced any of the following symptoms in the last year?

	Yes	No	If yes, please explain
Cough longer than three weeks	☐	☐	_____
Cough of blood	☐	☐	_____
Shortness of breath	☐	☐	_____
Chest pain	☐	☐	_____
Persistent weight loss without dieting	☐	☐	_____
Night sweats	☐	☐	_____
Chills/fever	☐	☐	_____
Fatigue (more than usual)	☐	☐	_____

Print Name: _____ Student ID: _____

Signature: _____ Date: _____

For Office Use Only

Reviewed By: _____

College of Health and Society
45-045 Kamehameha Highway
Kāne'ohe, HI 96744
USA

T: +1.808.236.3552
F: +1.808.236.3524