GASTON COLLEGE Health & Human Services

Student Health Information Packet

Welcome to Gaston College! We are so glad that you chose to complete your education in one of our outstanding health programs. As part of your participation in the program, you will be required to submit important health information to be a part of your Student Health Record that is maintained in a system called "Complio." To assist with creating your health record in Complio, please review and follow the statements, information, and instructions below.

- Students must maintain a copy of all documentation submitted to Complio.
- All records must be verified with a **signature and stamp of a healthcare provider**.
- Students will be ineligible to participate in Clinicals until the Health Record is completed.
- **Students must submit five (5) pages (the Student Health Record Page and Forms A-D or pages 3-7 are required for approval.)**

STUDENT HEALTH RECORD

Submission Deadline	Submit the completed Health Record on or before the designated due date for the program that you are applying to.
You can submit your documents to Complio in the following ways:	a. Scan and upload from your computer b. Use your mobile phone to access Complio, then take photos to submit documents
Questions?	Contact - Amy Heavner, Compliance Specialist, heavner.amy@gaston.edu or 704-922-6379

PHYSICAL EXAMINATION BY A HEALTHCARE PROVIDER (FORM A)

Examination by Healthcare Provider (Using Form A – Student Health Evaluation)	Only a physician, physician assistant, or nurse practitioner shall perform the physical examination.
Hearing and Color Vision Tests	Hearing and vision tests must be included as part of the Physical Examination. Vision test must include a color vision test due to clinical skills where visualization of color is necessary to patient care.
Signatures/Facility Stamp	The Physical Examination and Immunization Record forms must include the healthcare provider's signature and the address/phone number or facility stamp.

PROGRAM ESSENTIAL FUNCTIONS/COMPETENCIES (FORM B)

Program Essential Functions (Form B)	Each Program has a list of competencies which students must be able to perform in order to successfully complete the learning outcomes. Only a Medical Doctor (MD), Physician Assistant (PA) , Nurse Practitioner (NP), or Doctor of Osteopathic Medicine (DO) can complete this section. IT MUST BE SIGNED BY BY THE APPLICABLE HEALTHCARE PROVIDER.
Submission of the Program Essential Functions Form	The Essential Functions Form will need to be uploaded to your Complio profile.

IN THE EVENT THAT A STUDENT DOES NOT MEET PROGRAM ESSENTIAL FUNCTIONS

Disability Services:

If a Gaston College Health Program Applicant or current student believes that he or she cannot meet one or more of the essential standards without accommodations or modifications, the college must determine, on an individual basis, whether or not the necessary accommodations or modifications can be reasonably made.

The Counseling and Career Development Center will assist and advise students with documented disabilities in arranging academic support and reasonable accommodations. Accommodations will be arranged on an individual basis, specific to need. The Counseling Center's goal is to provide students with disabilities reasonable accommodations so they may effectively participate in the program. Students must meet with the Special Needs Counselor and provide any and all necessary documentation to be considered for reasonable accommodation. Students must also meet with the Special Needs Counselor each semester to review the accommodation plan to continue accommodation.

If you think you need special accommodations while attending Gaston College, please contact the Special Needs Counselor at 704.922.6224 or 704.922.6220 to schedule an appointment. You will complete a confidential Disclosure Form, and we will review and discuss your needs. You will need to provide written and signed documentation by a credentialed professional, usually within the past three years, that states your diagnosis or diagnoses and any limitations.

Change/Altered Student Health After Admission to a Health Program:

A change in the student's health during the program of learning so that the essential functions cannot be met, with or without reasonable accommodations, may result in withdrawal from the health program. The chairperson/coordinator of the program must be informed when there is any change in condition/health for students (e.g., pregnancy, injury, extended illness, hospitalization). An additional medical examination at the student's expense may be required in order to assist with evaluation of the student's ability to perform the essential functions of the Health Programs at Gaston College.

IMMUNIZATIONS RECORD (Form C)

All Programs EXCEPT VET TECH will need to provide proof of the following vaccines/immunizations: (Form C)	• MMR (Measles, Mumps Rubella) series of 2 or a positive titer • Hepatitis B, series of 3, or a positive titer, or a Gaston College declination form • Varicella, series of 2 or a positive titer • 2 step PPD or an approved blood test or clear chest x-ray and TB risk assessment (on admission) • Annual TB risk assessment • Seasonal Flu Vaccine • Tdap booster, within the past 10 years • COVID - Fully vaccinated per CDC guidelines
VET Tech Student Immunizations	• Rabies Vaccine • Tetanus & Pertussis Vaccine (Tdap within 10 years)

STUDENT SIGNATURE PAGE (Form D)

You must initial each statement at the top of the page to show you understand each requirement. You must sign and date the bottom of the page and return with the other pages of the Student Health Form.

To learn more information about these vaccines and the benefits/potential risks please visit the Center for Disease Control and Prevention website at *http://www.cdc.gov/vaccines/*.

NOTE: Vaccine requirements may change based upon industry standard and or Center for Disease Control recommendations. All students will be informed timely about any changes in required immunizations for admittance and or progression in a health program at Gaston College.

FULL Student Name: _____
Last First Middle

Gaston College Student ID #_____ Date of Birth_____

Program: *(Please check which program you are entering)*

- ☐ Associate Degree Nursing (Traditional)
- ☐ Associate Degree Nursing (LPN-RN)
- ☐ Central Sterile Processing
- ☐ EMS/Paramedic
- ☐ Health & Fitness Science
- ☐ Health Information Technology
- ☐ Medical Assisting
- ☐ Nurse Aide
- ☐ Pharmacy Technology
- ☐ Phlebotomy
- ☐ Practical Nursing (LPN)
- ☐ Surgical Technology
- ☐ Veterinary Medical Technology
- ☐ CaroMont Health Academy

GASTON COLLEGE Health & Human Services

Physical Examination by a Healthcare Provider (Form A)

To be completed by a healthcare provider (e.g., M.D., P.A., N.P., D.O.)

Student Name: _____

Date of Birth: (month/day/year)_____/_____/_____ Current Age: _____

Height:_____ Weight:_____ Blood Pressure:_____

Vision: Corrective Lenses? ☐ Yes ☐ No Color vision: Is student color blind? ☐ Yes ☐ No

Hearing: WNL? ☐ Yes ☐ No Hearing Aids? ☐ Yes ☐ No

Retina Normal ☐ Yes ☐ No

Please evaluate and indicate the student's body systems:

Body System	Normal	Abnormal	Notes/Description
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

A. Is the student currently under treatment for any medical or emotional conditions? ☐ Yes ☐ No
If "Yes" explain: _____

_____

B. Does the student have any life threatening allergies? ☐ Yes ☐ No
If "Yes" list allergen: _____

C. Does the student require use of Epipen? ☐ Yes ☐ No

D. Does the student require any other prescribed medications for life threatening allergy? ☐ Yes ☐ No
If "Yes" list medications required: _____

Healthcare Provider Signature

Print Name: _____

Signature:_____

Phone:_____Fax:_____

Date: _____

Address/Stamp (Required)

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Program Essential Functions/Competencies (Form B)

Student Name:_____ Date of Assessment:_____

The following essential functions are part of the health program of study. Please read each and assess the student's physical and emotional health and indicate if they are able to participate in the classroom, clinical, and lab activities of the program by checking "Yes or No."

Essential Function	Standard	Some Examples of Necessary Activity (Not all inclusive)	Assess-ment
Critical Thinking	Critical thinking ability sufficient for clinical judgment and decision making.	Identify cause and effect relationships in clinical situations, carry out care of client/patient correctly.	☐ Yes ☐ No
Inter-personal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural and intellectual backgrounds.	Establish rapport with clients, patients, and care givers and colleagues.	☐ Yes ☐ No
Commu-nication	Communication abilities sufficient for interaction with others in verbal and written form.	Explain treatment procedures, initiate health teaching as directed, document care, interpret results and communicate with other care givers with or without reasonable accommodations.	☐ Yes ☐ No
Mobility	Physical abilities sufficient to move from room to room, maneuver in small spaces, transport patients or animals in VET tech program as needed for care.	Moves around in patient / animal care rooms, work spaces and treatment areas. Administer cardio-pulmonary procedures with or without reasonable accommodations.	☐ Yes ☐ No
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective care.	Calibrate and use equipment; position client/patient with or without reasonable accommodations.	☐ Yes ☐ No
Hearing	Auditory ability sufficient to monitor health needs of patient/client.	Hears monitor alarms, emergency signals, auscultatory sounds, cries for help, with or without reasonable accommodations.	☐ Yes ☐ No
Visual	Visual ability sufficient for observation and assessment necessary in patient/client care.	Observes patient/client responses to care with or without reasonable accommodations.	☐ Yes ☐ No
Tactile	Tactile ability sufficient for physical assessment.	Perform palpation, functions of physical examination and or those related to therapeutic intervention, i.e. insertion of IV's, catheter, with or without accommodations.	☐ Yes ☐ No
Weight Bearing	Lifting ability sufficient for a variety of patient/client care settings.	Performs patient/client care that demonstrates the ability to lift and manipulate at least 50 pounds. *For EMS program able to lift and manipulate at least 170 lbs.	☐ Yes ☐ No
Temper-ament & Emotional Control	Remain calm, patient and react professionally to certain situations.	High stress clinical areas, working with others in healthcare (TEAM centered)	☐ Yes ☐ No

Healthcare Provider Signature

Print Name: _____

Signature:_____

Phone:_____Fax:_____

Date:_____

Address/Stamp (Required)

GASTON COLLEGE Health & Human Services

Immunizations Record (Form C)

Student Name: _____

Date of Birth: (month/day/year)_____/_____/_____ Current Age: _____

To be completed and signed by physician and or clinic. A complete immunization record is required and must be met in order to proceed in the program.

REQUIRED IMMUNIZATION	MO/DAY/YEAR	MO/DAY/YEAR	MO/DAY/YEAR	MO/DAY/YEAR
MMR (Measles, Mumps, Rubella)	#1	#2	OR	Titer date & results (attach proof)
Tdap Booster (Within 10 years)				
Hepatitis B	#1	#2	#3	OR Titer date & results (attach proof) OR Declination Form
Varicella (Chicken Pox) series of two doses or titer	#1	#2	OR	Titer date & results (attach proof)
COVID ☐ Pfizer-BioNTech ☐ Moderna ☐ Johnson & Johnson's Janssen	#1	#2	Booster	
SEASONAL VACCINE			**Date Received / Month/Year**	
Flu /Influenza Vaccine				
Tuberculosis - Two PPDs or an FDA approved blood test are required.			Date Read	
PPD #1 (date placed_____/_____/_____)			___ /___/___PPD#1	_____mm induration
PPD #2 (date placed_____/_____/_____)			___ /___/___PPD#2	_____mm induration
OR				
FDA approved blood test for TB (e.g. Quantiferon Gold) (attach report)			___ /___/___	☐ Positive ☐ Negative ☐ Indeterminate
RABIES Vaccine	**MO/DAY/YEAR**		**MO/DAY/YEAR**	**MO/DAY/YEAR**
For VET Tech Students **ONLY**	#1		#2	#3

Healthcare Provider Signature

Print Name: _____

Signature:_____

Phone:_____Fax:_____

Date:_____

Address/Stamp (Required)

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Student Signature Page (Form D)

A student in a health program at Gaston College must complete a clinical experience to successfully complete the program.

PART I: STUDENT NOTICE/HEALTH EDUCATION PROGRAMS

Please initial that you understand each requirement and have had your questions answered regarding these requirements.

_____ Criminal Background Check

_____ Obligation to Report Criminal Charges

_____ Drug Testing

_____ Healthcare provider physical and emotional assessment to perform the program's essential functions

_____ Obtain and maintain up-to-date CPR Certification (if applicable or required for selected program)

_____ Release of emergency contact information

PART II: AUTHORIZATION FOR OFF-CAMPUS CLINICAL RELEASE

Off-campus clinical facilities may require medical information on students in programs with clinical assignments. Gaston College is responsible for providing the clinical facility with medical data from a student's medical record. This data may include vaccinations received, medical test results, criminal background screens, and drug screen results. The facility may also require that the student provide a copy of their medical record, if necessary, including emergency contact information for first aid and safety purposes in the event that medical treatment is required.

By signing below, I authorize Gaston College and the Health & Human Services Division to release and disclose any and /or all pertinent medical information as indicated in the above provision, to an affiliating clinical facility that requires this information as a condition of my assignment to the facility.

I understand that if I refuse to release my medical information to Gaston College /clinical facilities, I may lose my eligibility to continue as a student in a Gaston College health program. I further understand that failure to release the records may result in the facility denying my clinical assignment, which may prevent me from fulfill the program's requirements for completion and graduation.

_____ _____ _____

Printed Name of Student Signature of Student Date

_____ _____

Signature of Parent or Legal Guardian Date

(If student is under the age of 18)

****The signature of the student's parent or legal guardian is required if the student is under 18 years of age****