CHKDHS
STUDENT/FACULTY PROFILE

The following information must be completed and validated by the affiliated organization prior to commencement of a student rotation. PLEASE PRINT OR TYPE LEGIBLY.

Student Information:

Student Full Name: _____

Student Address: _____ City: _____ Zip: _____

Phone (Home**):** (___)_____ Work: (___) _____Pager: _____e-mail: _____

CHKD location requested _____ Type of Student _____

Rotation Start Date: _____ End Date:_____

Student Emergency Contact(s):

Emergency Contact Name: _____ Relationship:_____

Address: _____ City: _____ Zip: _____

Phone (Home): (___)_____ Work: (___)_____Pager: _____E-mail: _____

Emergency Contact Name: _____ Relationship:_____

Address: _____ City: _____ Zip: _____

Phone (Home): (___)_____ Work: (___)_____Pager: _____E-mail: _____

School Information:

Name of School: _____ Director of Program /Contact Person:_____

Address of School: _____ City: _____ Zip: _____

Director of Program Phone: ( )_____ Instructor(s) Name: _____

Instructor Contact: Phone: _( )_____ Pager: _____ E-mail:_____

Affiliation Agreement Contact: _____ Title: _____

Phone Work: (___)_____Pager: _____E-mail: _____

School Contact for Student Emergency:

Name: _____ Title: _____ Phone: _____ Pager: _____

Other Information (allergies, chronic illness, limitations):
_____
_____
_____
_____
_____

Immunity Status Information: The affiliated program personnel acknowledge that student's immunity status was verified by signing the boxes below or the student has attached documentation from a healthcare provider.

Immunity	Signature	Immunity	Signature
Measles, Mumps, & Rubella: ❑ Proof of two (2) MMR vaccines after 1 year of age. ❒ Proof of immunity to Measles, Mumps and Rubella (positive titers)		**Tuberculosis:** ***Evidence of a two-step PPD or baseline IGRA blood test. PPD symptom screening is accepted during PPD shortages. Annual negative sign/symptom screen thereafter. (If 12 months pass with no screening, a TB test is required.)*** ❑ **TB testing Negative**: Attach results from healthcare provider if school not verifying. ❒ **History of TB infection/disease or positive PPD**: Negative chest x-ray since positive PPD and attach documentation from healthcare provider not currently infectious and includes a negative assessment for signs and symptoms.	Dates of initial two step testing or baseline IGRA blood test: PPD # 1 Date: ___/_____/_____ PPD # 2 Date: ___/_____/_____ Date of symptom screen/IGRA: __/_____/_____
Hepatitis B Vaccine: ❑ Series Completed/In Progress ❑ Positive Hepatitis B Titer ❑ Documented declination of vaccine			
Varicella (Chicken Pox): ❑ Physician documented chicken pox disease ❑ Positive Varicella Titer or 2 vaccines.		**Influenza Immunization (Students rotation during Influenza Season):** ❑ Documented influenza vaccination for flu season (generally from November 1 to March 31 of each year or according to CDC) ❑ Vaccine exemption requests must be approved by the school and submitted to the facility for review and approval.	

Student Automobile Insurance Verification (required if traveling from site to site for rotations): This section is only for students of programs where this verification is required. It does not apply to inpatient nursing rotations.	**Student Signature**
The student's automobile insurance meets the affiliated agreements guidelines.	

Medical Examination/Screening/Drug Testing	**Student Signature**
I have been informed that upon the request of the Facility, I must submit to (or submit information regarding) a medical examination/screening and/or drug testing/screening at my own or my School's expense.	

Nationwide Criminal History and Sexual Offender Background Check

I have completed a nationwide criminal history and sexual offender background check at my expense or at my School's expense.

❒ **Copy Attached Student Signature: _____** Date: _____

❒ **Verification Signature: _____** Date: _____

If concerns are identified, the individual case must be discussed and cleared with CHKDHS Director of Human Resources (757-668-7128) prior to commencement of the rotation. Human Resource Director Signature (if applicable): _____Date: _____

Pre-Rotation Training Validation (Completed by Student & Verified by Program Representative)

❑ Participant has successfully completed the programs pre-clinical education as described in the course curriculum
❑ Bloodborne Pathogen Training
❑ Current Adult/Child & Infant CPR card (if applicable)

Student Signature: _____ Date: _____
Program Representative Signature: _____ Date: _____

Pre-Rotation Training Validation (Completed by Student)
I have read and understand the information contained in the "Standards of Information" packet.

Training:	Student Initials:	Training:	Student Initials:	Training:	Student Initials:
Infection Control Standard Precautions Transmission-Based Precautions Tuberculosis		Dress Code Identification Cellular Phone Use Parking Information		Culturally Competent Care	
Radiation Safety		Drug and Alcohol Free Workplace Tobacco Free Organization		Age Specific Care	
Guest Relations/Conduct		Equal Opportunity Employment Sexual Harassment and Other Types of Harassment Corporate Compliance		Emergency Response Procedures	
Patient / Family Rights and Responsibilities		Patient Safety		Safety Data Sheets	
Confidentiality / Proprietary Information		The Joint Commission National Patient Safety Goals and Standards		Equipment Safety Safe Medical Device Act	

Falsification of information provided will result in rejection of the student for the program rotation and can further jeopardize continued affiliation with the Facilities program. The student information provided is true and factual without misrepresentation. I understand that the above information will only be shared with personnel within the Facility who requires this information for Safety and Security.

Student Name (print): _____ **Student Signature: _____** **Date: _____**

The form is complete and the student has been given the Facility student information packet and safety information for review. The student has been instructed on maintaining the form on their person and filing the completed form with the clinical coordinator.

Program Representative Name (print): _____ **Signature: _____** **Date: _____**

Send or bring completed form to the Facility prior to commencement of the student rotation. Faculty not on-site or for off-site rotations, the student must maintain a completed copy of the front portion of this form on their person during the rotation.