ACKNOWLEDGMENT OF RECEIPT OF BACKGROUND CHECK POLICY

I certify that I have accessed a copy of Wallace State Community College's Background Check Policy and Guidelines (available online at http://www.wallacestate.edu/programs/health-division). I have read and understand the requirements of the policy and guidelines.

_____ _____

Date Student's Signature

_A_____ _____

Student Number Student's Name Printed

ACKNOWLEDGMENT OF RECEIPT OF REVISED DRUG AND ALCOHOL TESTING POLICY

I certify that I have accessed a copy of Wallace State Community College's Drug Testing Policy and Guidelines (available online at http://www.wallacestate.edu/programs/health-division). I have read and understand the requirements of the policy and guidelines.

_____ _____

Date Student's Signature

_A_____ _____

Student Number Student's Name Printed

_____

Parent's/Legal Guardian's Signature (If student is a minor)

HEALTH SCIENCE DIVISION CONSENT TO ALCOHOL AND DRUG TESTING

I have received and carefully read the Drug testing policy and fully understand its contents. I understand that by enrolling in a health professional program, I will be required to submit to mandatory drug testing. I voluntarily agree to submit to specimen collection for analysis for alcohol and drug use. I understand that my continued participation in the healthcare program is conditioned upon satisfaction of the drug testing requirement through the college designated vendor. **I further understand that if I have a positive drug screen that I will be dismissed from the program. A grade of "F" will be recorded for the course(s) if I do not officially withdraw.**

I further agree and consent to the disclosure of results of drug testing and their release to the Dean of Health Sciences, program director and appropriate clinical representative(s) in order that my eligibility to participate in the required clinical activities can be determined.

_____ _____

Date Student's Signature

_____ _____

Student Number Student's Name Printed

_____

Parent's/Legal Guardian's Signature (If student is a minor)

Background Check Consent and Release Form

I have received and carefully read the Background Check policy and fully understand its contents. I understand that the healthcare program to which I am admitted requires a background check to comply with clinical affiliate contracts. By signing this document, am indicating that I have read and understand Wallace State Community College's policy and procedure for background checks. I voluntarily and freely agree to the requirement to submit to a Background Check and to provide a negative Background Check prior to participation in clinical learning experiences. I further understand that my continued participation in the healthcare program is conditioned upon satisfaction of the requirement of the Background Check with the vendor designated by the College. **I further understand that if I have a positive Background Check and I am denied access to clinical learning experiences at the clinical affiliates(s), that I will be dismissed from the program. A grade of "F" will be recorded for the course(s) if I do not officially withdraw.**

A copy of this signed and dated document will constitute my consent for release of the original results of my Background Check to the College. I direct that the vendor hereby release the results to the College. A copy of this signed and dated document will constitute my consent for the College to release the results of my background check to the clinical affiliate(s)' specifically designated person(s). I direct the College to hereby release the results to the respective clinical affiliate(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 check 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 Check, 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 by anyone. I hereby authorize the College's contracted agents to procure a background check on me. I further understand this signed consent hereby authorizes the College's contracted agents to conduct necessary and/or periodic background checks as required by clinical affiliates.

_____	_____
Student Signature	Witness Signature (friend, relative, etc.)
_____	_____
Student's Printed Name	Witness' Printed Name
_____	_____
Parent's/Legal Guardian's Printed Name (If student is a minor)	Parent's/Legal Guardian's Signature (If student is a minor)
_____	_____
Date	Date

Acknowledgment of Standard Clinical Vaccination / Immunization Requirements

I understand that I am applying to a Wallace State Community College Health Division degree program that requires clinical or fieldwork classes that are conducted at off-campus clinical facilities managed by a contractual agreement. As non-employee guests in the contracted facility, I understand that admitted students are required to demonstrate compliance with a variety of safety measures, including but not limited to standard vaccination requirements. At a minimum, all clinical contracts include each of the following items:

- **Hepatitis B** – requires the series of three (3) shots
- **MMR** - Measles (Rubeola), Mumps, Rubella – requires two (2) shots
- **Varicella** (Chickenpox) - requires two (2) shots; history of the disease is not sufficient
- **Tetanus** (TDAP) - must be current within 10 years and have documentation of one TDAP as an adult.
- **Flu** vaccine – requires one (1) shot, received during September or October annually.
- **Two Step Tuberculin Skin Test** – Mantoux. Annual One Step thereafter. (Negative chest x-ray, negative T-Spot, negative IGRA or negative QuantiFERON Gold Blood test may be accepted in lieu of Mantoux.)

I understand that the above listed vaccinations/immunizations are required, and current contracts do no permit medical or religious exemptions for these standard safety measures. Additional contract or facility specific requirements, including but not limited to the COVID-19 vaccine, may also be required based on individual facility contract requirements.

By signing this agreement, I acknowledge that I will be required to provide documentation of the vaccinations listed above. Further, I acknowledge that I am willing and able to provide that documentation and I assume full responsibility for any associated costs involved in obtaining or providing this information. I also acknowledge that my refusal to be vaccinated or to provide the supporting documentation will result in a situation where appropriate clinical placement is not available, eliminating the possibility of successfully completing/graduating from the program to which I am applying.

_____

Signature of Student Date

_____

Printed Name of Student

_____

Signature of Parent/Guardian (if student under 18) Date

_____

Print Name of Parent/Guardian (if student under 18)

Assumption of the Risk and Waiver of Liability
Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization**. COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Wallace State Community College ("the College") has put in place preventative measures to reduce the spread of COVID-19; however, the College **cannot guarantee** that you will not become infected with COVID-19. Further, **attending the College, participating in College lead classes, trainings or labs could increase** your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending the College and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the College may result from the actions, omissions, or negligence of myself and others, including, but not limited to, College employees, other students, vendors or affiliates and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my attendance at the College or participation in College activities ("Claims"). On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless the College, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the College, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any College services.

Signature of Student **Date**

Print name of Student

Signature of Parent/Guardian **Date**

Print Name of Parent/Guardian (if student under 18)

Coronavirus/COVID-19 Vaccine –
Limited Clinical Availability Acknowledgement

Due to the ongoing nature of the COVID-19 pandemic and the increased risk of exposure while involved in clinical education, the Physical Therapist Assistant (PTA) Program recommends that all students be vaccinated. While this is not a Wallace State Community College requirement at this time, numerous PTA Program clinical facilities are independently requiring all healthcare providers, including assigned students, to be vaccinated and refusing placement to non-vaccinated students. This is particularly true for acute care hospitals and skilled nursing facilities/nursing homes. (*As of July 1, 2022 the PTA program does not have a single acute care or skilled nursing/nursing home facility contract that will accept non-vaccinated students.*) Therefore, a student who refuses to have the COVID-19 vaccine may face significantly greater limitations in finding clinical placement options or may find themselves in a situation where clinical placement options are not available.

By signing this agreement, I acknowledge that should I refuse to take the COVID-19 vaccine, I may be required to travel significant distances (in excess of two hours) to available placement locations, and I assume full responsibility for any increased costs associated with such placements. I further acknowledge that my refusal to be vaccinated may result in a situation where appropriate clinical placement may not be available within the regularly scheduled clinical timeframes, significantly delaying program completion and graduation. Ultimately, I acknowledge that if appropriate clinical placements cannot be located, I will be unable to complete the PTA Program and must withdraw from the program, regardless of grades achieved and courses completed.

_____

Signature of Student Date

_____

Printed Name of Student

_____

Signature of Parent/Guardian (if student under 18) Date

_____

Print Name of Parent/Guardian (if student under 18)