College of DuPage

EMT & PARAMEDIC

CLINICAL REQUIREMENTS

Please read this packet carefully as some requirements have changed. Previous versions of this packet are not in force and will not be honored.

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CLINICAL REQUIREMENTS OVERVIEW

As a student of the College of DuPage (COD) Nursing and Health Sciences Division programs, the completion of all clinical requirements is mandatory. Depending upon the program to which you are applying, medical requirements may need to be completed prior to registration or after program admission. Please see the specific program registration or application packet for detailed information on when to begin completing health requirements, drug tests, CPR, criminal background checks and proof of insurance submission.

College of DuPage has partnered with Edward Occupational Health (EOH) to ensure compliance of students' medical requirements. Any charges are the student's responsibility and are due at the time of service. It is recommended that students verify with their insurance provider whether required services are covered by their personal health insurance. It is ultimately the student's decision where they complete their health requirements. EOH, or provider of your choice, may complete all of the services; however, EOH **must** complete the required chart review. Please note: College of DuPage will not receive any of your medical records; they are your and your health care provider's responsibility and property. **EOH will provide a clearance form directly to you and College of DuPage**.

To access EOH's services, call the various location(s) (see page 7), identify yourself as a College of DuPage student and discuss what services you need. You must bring all required documentation to EOH for a Chart Review.

The background check and drug screen must be completed through the College of DuPage ***CastleBranch account*.** CNA students' background checks will be completed after registering for the course.

CLINICAL REQUIREMENTS INFORMATION

The following immunizations are mandated by the clinical site (on-campus & off-campus) and are important for our commitment to public safety including personal safety from exposure to potential disease during clinical work.

Please **do NOT** begin until instructed to do so by the Division Office

Requirement	What
Physical Examination	A summary of the physical exam performed by your primary care provider (i.e. MD, NP)
Flu Vaccine	Vaccine given annually. (The flu vaccine is seasonal and changes every year in the Fall). You must obtain proof of the current flu vaccine. Proof of current vaccination **MUST** include the following: (1) Student name (2) Clinic name (3) Date administered (4) Lot Number (CNA Only)
Tetanus/Diphtheria/Pertussis Vaccination (TDAP)	Obtain a one-time dose of TDAP if you have not previously received. Obtain TD boosters every 10 years thereafter.
QuantiFERON TB Gold Blood Test	Blood test that aids in the detection of *Mycobacterium tuberculosis*, the bacteria which causes tuberculosis (TB). This test is done annually. A positive QuantiFERON-TB Gold result means that the person has been infected with TB bacteria and should be followed by further medical and diagnostic evaluation to determine if the person has latent TB infection or TB disease. **A chest x-ray will be required.**
Titers for: **Hepatitis B Titer** **Varicella – (Chicken Pox)** **MMR – Rubeola (Measles), Mumps and Rubella (German Measles)**	Documented antibody/IGG (quantitative) titer levels indicating immunity (blood draw to demonstrate your immune status to identified communicable diseases). To be effective, the blood test must indicate that you are positive for immunity.
Chart Review **MUST** be done by Edward Occupational Health	All medical records must be reviewed by Edward Occupational Health. A clearance form will be completed at your appointment. Please allow plenty of time to get all requirements completed and reviewed by Edward Occupational Health.
CPR Card **Does Not Include EMT (Fire 2271).**	Must be **American Heart Association – BLS for Health Care Providers**. Card must be signed by student. Must be valid through the entire length of chosen program.

Requirement	What
	(Some programs will complete this requirement during class. Please refer to your program specific clinical instructions for more details.)
Medical Insurance	Can be purchased through the college's insurance carrier. Please visit Student Health Insurance website for details. Must be comprehensive health insurance and valid through entire length of chosen program. The student is responsible for any costs that may be incurred related to personal injuries he/she may acquire while performing activities at the clinical affiliate. If you do NOT have health insurance, please see potential resources below on how to obtain coverage. Please know that the approval process can take up to 90 days. If you had a "**Life Event" change**, then you may qualify for a Special Enrollment Period (SEP). Please visit https://getcovered.illinois.gov/special-enrollment-period/special-enrollment.html to view list of "Life Events" to see if you qualify. **OR** If you did not have a "Life Event" change from above, you should start the application process for Medicaid **NOW, by visiting Applying for Medicaid.**
CastleBranch	
Medical Document Manager	If required by your program, all medical documents must be uploaded to CastleBranch once the chart review is complete. Students will have unlimited access to their Medical Documents through graduation and beyond.
Background Check - excluding CNA students	Background Checks are completed through CastleBranch. **Please do NOT begin until instructed to do so.** Background checks for **CNA students** follow a program-specific process. Please consult the C.N.A registration packet for details. Additional information is provided after registration approval. All students are required to undergo a criminal background check in order to participate in the programs clinical rotations. A student with a positive background check containing disqualifying conditions as defined by Federal and State law will not be allowed to enter the clinical portion of the program. A student with a positive background check containing disqualifying convictions as defined by Illinois State Law (225ILCS46/25) and 77 Ill Adm. Code 955 Section 955.160 will not be allowed to enter the clinical portion of this program, thus preventing the student from obtaining mandated certification and/or licensure.

Requirement	What
Drug Test	A 10-panel urine drug test will be used to identify the presence of Marijuana, Cocaine, Phencyclidine, Amphetamines/Methamphetamines, Opiates, Barbiturates, Benzodiazepines, Methadone, Methaqualone & Propoxyphene. **Please do <u>NOT</u> begin until instructed to do so.** (Refer to specific program instructions for appropriate package code and further details) Positive results on a drug screen, or misrepresentation regarding drug use, will lead to immediate dismissal from, or non-admittance to the particular program(s). When a student is dismissed from or not admitted to a program for a positive drug screen, they may reapply to that program, or any other College of DuPage health program for the admission cycle of the subsequent semester. (NOTE: For 8-week programs, the student must wait until the next semester for potential re-admittance). Drug testing (performed at the student's expense) will again precede clinical experience in all cases and will be required prior to readmission in some programs. Program re-admission policies vary for each program. The student should contact their respective Program Chair or consult the program handbook for additional information. Re-admission is not guaranteed. **IMPORTANT NOTE**: 'Positive' results for Marijuana will **<u>NOT</u>** be accepted as marijuana is not federally regulated. This means that if you receive a 'positive' result for Marijuana, you will **<u>not</u>** be able to move forward in the program as the clinical sites require a 'clear' drug test. FYI, marijuana can remain in your system for at least 4-8 weeks. Please note that even if you had a prescription for medical marijuana, it will still not be accepted. If you receive a *"dilute negative"* result, this means that your urine was too diluted to obtain an accurate result and you need to re-pay and take a new drug test. Please be cognizant of how much liquid you drink. It is best to try to schedule the test first thing in the morning when the sample will be most concentrated, if possible. Non-compliance will lead to violation of EMS & Fire Science Policy for Professional Conduct.

CLINICAL REQUIREMENTS PRICING

Edward Occupational Health Services Offered	Cost
Physical Examination (includes Color Vision)	**$69**
Flu Vaccine – Note: The flu vaccine is seasonal and changes every year in the Fall.	**$30**
Tetanus/Diphtheria/Pertussis Vaccination (TDAP)	**$85**
QuantiFERON TB Gold Blood Test	**$100**
Hepatitis B Antibody/IgG Titer	**$54**
Varicella Antibody/IgG Titer (Chicken Pox)	**$70**
Rubeola Antibody/IgG Titer (Measles)	**$43**
Mumps Antibody/IgG Titer	**$33**
Rubella Antibody/IgG Titer (German Measles)	**$33**
Chart Review - This **MUST** be done by Edward Occupational Health	**$38**
Edward Occupational Health Services Possible Additional Services	**Cost**
MMR Vaccine (per dose)	**$100**
Varicella Vaccine (per dose)	**$170**
Hepatitis B Vaccine (per dose)	**$82**
Tetanus/Diphtheria (TD-Booster)	**$77**
TB Positive PPD Form	**$13**
Chest X-Ray	X-ray – Chest 2 views - $59 Tech Fee – Chest X-ray 2 Views - $70
CastleBranch Services	**Cost**
Drug Test – Do **NOT** begin until instructed to do so	**$33.99**
Background Check – Excluding C.N.A. students	**$72.99**
Medical Document Manager	**$19.49**

EDWARD OCCUPATIONAL HEALTH SERVICES LOCATIONS

You **MUST** visit one of these locations to complete an **in-person** Chart Review

Hours & Locations

Scheduling Line: (630)527-7299 – Option 2

ADDISON 303 W. Lake Street Addison, IL 60101 8:30 am – 5:00 pm Mon – Fri	**ELMHURST** 1200 S. York Street, Suite 1509 Elmhurst, IL 60126 7:00 am – 5:00 pm Mon – Fri
BOLINGBROOK 130 N. Weber Rd. Ste. 105 Bolingbrook, IL 60440 8:00 am – 6:00 pm Mon – Fri 8:00 am – 12:00 pm Sat	**NAPERVILLE** 100 Spalding Dr, Suite 212 Naperville, IL 60540 7:00 am – 5:00 pm Mon – Fri

PHYSICAL EXAMINATION FORM

College of DuPage - 425 Fawell Blvd, Glen Ellyn, IL 60137

This form must be completed by your physician and brought to Edward Occupational Health for your Chart Review

Please Print

Name _____

Last First

Health Program _____ Date of Birth (MM/DD/YYYY) _____ SS# _____-_____-_____

Must be completed by a licensed medical professional

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Physical Findings - **Must be completed by a licensed medical physician, nurse practitioner or physician assistant.**

Body Systems	Normal	Abnormal, please describe
Cardiovascular		
Eye		
Ear, Nose, Throat		
Conversational Hearing		
Color Vision		
Gastrointestinal		
Metabolic-Endocrine		
Musculoskeletal		
Neurological		
Respiratory		
Skin (Exposed areas only)		
Lymph Nodes		

Is student presently under any medical treatment? If yes, please explain:

_____

_____

_____

Conclusion: (check one)

☐ The student is medically cleared for the College of DuPage health program.

☐ The student is medically cleared for the College of DuPage health program with the following **accommodation(s)/restriction(s)**.

_____

_____

☐ The student **has <u>not</u>** been medically cleared for the College of DuPage health program.

Examiner's Name (*Please Print)* _____ Date of Examination_____

Signature of Examiner _____

EDWARD OCCUPATIONAL CHART REVIEW FORM

NURSING & HEALTH SCIENCES DIVISION CHART REVIEW

********Form is filled out by Edward Occupational Health - NOT STUDENT********

College of DuPage Program Name: _____ **Semester Clinicals begin**: _____

Be advised that**: LAST NAME**: _____ **FIRST NAME**: _____

(PLEASE PRINT)

☐ **Physical Exam Date:**_____

☐ **Flu Vaccine Date:**_____

Clinic Name: _____

Clinic Address:

_____

_____

Manufacturer: _____

Lot #: _____

☐ **Tdap Vaccine Date:**_____

☐ **Td Booster if applicable Date:**_____
(Original Tdap vaccine date required)

☐ **QuantiFERON-TB Gold Blood Test Date**: _____

Result: _____ Expires: _____

Only If medically necessary:

☐ **Chest X-Ray Date**:_____

Result:_____ Expires: _____

☐ **Annual TB Questionnaire Date**: _____

"Negative" Chest X-Ray in past? (circle) Yes **OR** No

Date of *"Negative"* Chest X-Ray: _____

Immunity (status) – Positive Antibody/IgG Titers Required for: Hepatitis B, Varicella and MMR.

HEPATITIS B:

For negative or equivocal titer results:

- The complete vaccine series must be completed. **Titer is to be completed 4 weeks subsequent to completion of series.**

Hepatitis B Original Vaccine Series:

☐ **1st Administration Date:**_____

☐ **2nd Administration Date:**_____

☐ **3rd Administration Date:** _____

☐ **Hepatitis B IgG Antibody Titer**

Titer Date:_____ **Result**:_____

Negative or Equivocal Titer:

Vaccine Booster Series

☐ **4th Administration Date:**_____

☐ **5th Administration Date:**_____

☐ **6th Administration Date:**_____

☐ **Repeat Titer Date:**_____ **Result:**_____

VARICELLA:

For negative or equivocal titer results:

- **If vaccination series was previously administered, one booster is required. Titer is to be completed 4 weeks subsequent to administration of booster.**
- **If vaccination series has not been previously administered, the series must be completed and followed by a titer 4 weeks subsequent to the completion of the series**

Varicella Original Vaccine Series

☐ **1st Administration Date:_____**

☐ **2nd Administration Date:_____**

☐ **Varicella IgG Antibody Titer**

Titer Date: _____ Result: _____

Negative or Equivocal Titer:

☐ **Booster Date:_____**

☐ **Repeat Titer Date: _____ Result:_____**

Measles (Rubeola), Mumps & Rubella (MMR):

For negative or equivocal titer results:

- **If vaccination series was previously administered, one booster is required. Titer is to be completed 4 weeks subsequent to administration of booster.**
- **If vaccination series has not been previously administered, the series must be completed and followed by a titer 4 weeks subsequent to the completion of the series**

☐ **MMR Original Vaccine Series**

☐ **1st Administration Date:_____**

☐ **2nd Administration Date:_____**

☐ **Measles (Rubeola) IgG Antibody Titer**

Titer Date:_____ **Result**:_____

☐ **Mumps IgG Antibody Titer**

Titer Date:_____ **Result:**_____

☐ **Rubella IgG Antibody Titer**

Titer Date:_____ **Result:**_____

Negative or Equivocal Titers:

☐ **Booster Date:_____**

☐ **Repeat Titer Date:_____ Result**:_____

NON-RESPONDERS have been counseled by a healthcare professional regarding precautions to prevent infection.

_____ _____

Initial Date

1. ☐ Records have been reviewed and/or examination has been performed by physician. Based on the information, student is clear to perform job duties without physical restrictions.

2. ☐ Cleared with the following restriction (restrictions may prevent acceptance into program).

_____

_____

3. ☐ Based on Physician's report and/or other diagnostic findings, student is **NOT** medically cleared for the health program at the College of DuPage.

_____ _____

Signature Date

AUTHORIZATION FOR THE RELEASE OF STUDENT INFORMATION

Clinical agencies may require the names of students who will be participating in a clinical or professional experience at their facility. Additionally, clinical agencies may request personally identifiable information (PII) which may include, but is not limited to, protected health information (PHI), background check and drug screening results. When requested, the Nursing and Health Sciences Division would be required to provide these documents.

Additionally, professional testing services or regulation agencies will need to be given student information, such as attestation of program completion and a student's Social Security Number. When requested, the Nursing and Health Sciences Division would be required to provide these documents.

As such, students are mandated to provide their consent to the release of student information. Failure to consent to the release of student information will prohibit student eligibility in a clinical or professional experience which may result in dismissal from the program.

I, hereby, authorize the Nursing and Health Sciences Division to release, upon request of a clinical agency, my personally identifiable information (PII) which may include, but is not limited to, protected health information (PHI), background check and drug screening results.

_____ _____

Signature **Date**

_____

Print Name

_____

Program Name