Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

VETERINARY SCIENCE EDUCATION

SENIOR CLINICAL HANDBOOK

2021-2022

HILLSBOROUGH COUNTY PUBLIC SCHOOL
HEALTH SCIENCE

Student Information for Health Science Program

Students in Veterinary Science programs work in complex, stressful situations that require critical judgment and decision-making. It is our legal and ethical obligation to affiliating agencies and the community to ensure insofar as possible, that our students are safe and stable practitioners.

Many of the careers in Health Science require graduates to take examinations for licensure or certification. Each of these occupations has their own professional board, which has rules and regulations that are governed by law. It is the responsibility of each professional board to issue, suspend, and revoke licenses and provide disciplinary actions for infractions. Upon completion of those programs that are under a professional board, graduates must be eligible for licensure in order to secure and maintain employment.

The following information has been developed using advice from affiliating facilities, credentialing agencies' guidelines, and Core Performance Standards for Admission and Progression that were developed by the Southern Council on Collegiate Education. Our intent is to ensure that our students are safe practitioners, and that our graduates will be eligible for credentialing by the appropriate board and meet the requirements of employment.

ACADEMY OF HEALTH PROFESSIONS
CLINICAL REQUIREMENT FORM

All Academy of Veterinary Science seniors will have to complete clinical rotations as part of their medical program of studies. Below are the prerequisites for our students before they go to their clinical experiences. We recommend completing the packet during the summer break.

All seniors are required to complete the following by the due date listed below. This packet accounts for *30%* of the student's veterinary science program grade for the first nine weeks. Completed packet and all fees are due on Monday, September 13, 2019 for an "A". The student will lose a letter grade for each day the packet and/or fees are late.

1. Purchase required scrubs (Purple) with the embroidered program logo. Uniforms are to be clean and wrinkle free.
2. Purchase athletic shoes to wear with scrubs. *All fees are the student's responsibility: $13.50 for Professional Liability Insurance, $7.50 for Student Accident Insurance, and $34 for a 12-panel drug screening for a total of $55.00.
3. Turn in Student Information Forms – Health History and Physical Exam. **TB test** and **flu vaccines** are required prior to the first clinical rotation. The **manufacturer, lot number and expiration date for the flu vaccine must be documented.**
4. Turn in the Infectious/Communicable Disease Contact Release Form **(must be notarized)**
5. Turn in the Verification of Medical and Hospitalization Insurance form
6. Sign and Return this Clinical Requirement form
7. Turn in the Medical Release form (**requires notary**).
8. Turn in the Instructional Field Trip and media release forms.
9. Turn in the statement of confidentiality (**requires notary**).
10. Maintain a passing grade in the veterinary science program of study. **Excessive absences, unsatisfactory academic progress and/or inappropriate behavior** will preclude a student from participating in clinical rotations, which will affect the overall grade.
11. **Inappropriate behavior or dress** will result in **immediate removal** from the clinical site and could lead to a failing grade for the clinical week.
12. No artificial nails and/or polish are allowed. No clear polish. Nails must be short.
13. Cologne or perfume is not to be worn on clinical rotations
14. Make-up must be conservative – no false eyelashes allowed.
15. Maintain hair a natural and appropriate color. If hair is colored or highlighted it must look natural; roots are not to be visible. **No** fancy combs or barrettes are permitted. Hair must be off the collar, pulled away from the face, and **neatly** secured so it is not a source of contamination.
16. **No facial piercings are allowed** during clinical rotations. This includes tongue piercings and clear piercing retainers.

17. Jewelry is **limited** to a watch with a second hand, one **small** stud earring per ear lobe, and a medic alert tag or bracelet. **No necklaces, bracelets, or rings are to be worn.**
18. Chewing gum is **not** allowed especially at clinical sites.
19. Socks or hose must be worn with the uniform.
20. Facial hair on males must be clean shaven. Beards are to be neatly trimmed.
21. Tattoos must be covered at all times. They should not be visible.
22. It may be the parent's responsibility to provide transportation to and from the clinical sites.
23. There are **no breaks on clinical time**. A 30 minute lunch is allowed.

*All fees are subject to change

Student ID is required daily to attend clinical rotations.

Tentative Clinical Dates for the 2021-2022 School Year:

November 1 – 5, 2021
February 7 – 11, 2022
March 28 – April 1, 2022

Failure to comply with ***ALL OF THE ABOVE REQUIREMENTS*** will jeopardize the student's participation in the clinical experience and will affect the student's grade in his/her medical program of study.

All Academy of Veterinary students are required to complete 500 hours of lab/clinical experience. 250 Hours can be accrued through land lab experience. The other 250 hours are obtained through clinical rotations and the students' community service at an animal facility. Failure to complete and turn in these hours will result in **not receiving the certificate of proficiency for Veterinary Assisting (CVA).** *I understand that my son/daughter will need to complete all of the above requirements and I understand and agree to follow the clinical procedures and requirements.*

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

CLINICAL PROCEDURES AND REQUIREMENTS

ABSENCES/TARDIES

Each student is responsible for notifying the instructor, clinical site and school in advance if he/she is going to be absent or tardy to the clinical experience.

DRESS CODE

1. Uniforms identifying the student will be required as well as student ID badges
2. Scrub uniforms are to be clean and ironed.

*Jackets and coats may be worn on the bus or car but not in the clinical setting.
*Matching scrub jacket or sweater may be worn in the clinical setting.

3. Students **MAY NOT** go into a clinical setting without proper uniform.
4. Come dressed for clinicals-**NO DRESSING OR UNDRESSING ON BUS OR IN CAR.**

PROFESSIONAL GROOMING

1. Hair **MUST** be off the collar and pulled back away from the face.
2. No fancy combs or ribbons
3. Hair should be appropriate color.
4. Make-up must be conservative.
5. Nails will be worn short in length with no polish.
6. **No gum chewing**

PROFESSIONAL STANDARDS

A student may be referred for disciplinary action for the following reasons:

1. Violating standard safety practices in the care of patients.
2. Delaying or omitting care that is within the identified scope of practice for the chosen course of study.
3. Being found in any restricted or unauthorized area.
4. Violation of confidential information related to patients and/or medical test.
5. Aggressive, rude behavior to any instructor, hospital or clinical staff, physician, patient or fellow student.
6. Leaving the clinical facility without the permission of the clinical instructor.
7. No parents, friends or family members are allowed at the facility, only for drop off and pick-up.
8. No cell phones are to be used at the clinical sites.

The clinical agency may request that a student be withdrawn from a facility for violation of the above code.

VERIFICATION OF MEDICAL AND HOSPITALIZATION INSURANCE

I, _____have medical and

hospitalization insurance with _____

(Please write "No Insurance" above if the student does not have medical insurance.)

Policy #:_____Expiration Date: _____

I understand that I am responsible for expenses incurred from any incidents or accidents that may occur during the course of training.

X _____

Students Signature

X _____

Parental Signature

X _____

Date

HILLSBOROUGH COUNTY PUBLIC SCHOOLS
HEALTH SCIENCE

HILLSBOROUGH COUNTY PUBLIC SCHOOLS
VETERINARY SCIENCE

ACKNOWLEDGEMENT OF INFECTIOUS/COMMUNICABLE DISEASE CONTACT RELEASE FORM

I understand that during the course of their clinical training, _____
(Student Name)
will be working with individuals, patients and/or specimens from individuals who may have a communicable or infectious disease.

_____

Signature of Parents or Legal Guardian

_____

Relationship to student

_____

Date

_____

Signature of Notary Public

Notary Stamp:

2021-2022 SCHOOL YEAR
HILLSBOROUGH COUNTY PUBLIC SCHOOLS

STUDENT ACCIDENT INSURANCE PROTECTION PROGRAM
United States Fire Insurance Company

Who Is Covered
All students of the Hillsborough County Public School's Daycare, summer and Community Based Training Programs are covered while participating in school sponsored and supervised activities. All students are also covered while traveling, directly and without interruption, to and from any school sponsored or interscholastic athletic activity and his or her home or place of residence.

Accidental Death & Dismemberment
If a covered injury results in any of the losses specified below within one year after the date of the accident, the company will pay the applicable amount.

- Full Principal Sum for loss of life ($10,000.00)
- Full Principal Sum for double dismemberment ($10,000.00)
- 50% of the Principal Sum for loss of one hand, one foot or sight of one eye ($5,000.00)
- 25% of the Principal Sum for loss of index finger and thumb of same hand ($2,500.00)

If the Principal sum is payable, no indemnity will be paid for dismemberment. In any event, the double dismemberment indemnity is the maximum amount payable under this Benefit for all losses resulting from one accident.

Maximum Medical Expense Benefit
If the Covered Person incurs eligible expenses as the result of a covered injury, the Company will pay the charges incurred for such expense within 52 weeks, beginning on the date of accident. Payment will be made for eligible expenses in excess of other applicable insurance (if any), not to exceed the Maximum Medical Expense Benefit of $25,000.00. The first such expense must be incurred within 90 days after the date of the accident. "Eligible Expenses" means charges for the usual and customary medical procedures to promote necessary healing with the following limitations:
Hospital Inpatient Room & Board, Limited to $200.00 per Day
Hospital Outpatient Expense Emergency Room, Limited to $185.00 per Injury
Physicians Expense (Non-Surgical), Limited to $40.00 per Visit
Physicians Expense (Surgical), Limited to $3,750.00 per Injury
Diagnostic Imaging, Limited to $400.00 per Injury
Physiotherapy, Limited to $35.00 per Visit with a 5 Visit Maximum
Prescription Drugs, Limited to $250.00 per Injury

Exclusions and Limitations
This Plan does not cover any loss to or resulting from:

- Sickness or disease in any form, except pyogenic infections due to an accidental cut or wound.
- The use of drugs or narcotics, unless administered under the advice of a physician.
- War or any act of war, whether or not declared.
- Participation in any riot or civil commotion.
- Air travel or the use of any device or equipment for aerial navigation, except as a fare-paying passenger on a regularly scheduled commercial airline.
- Suicide or any attempt thereat or any self-inflicted injury.
- Service provided by any person or facility employed or retained by the Policyholder or member organization.
- Service provided by any member of the Insured Person's family or household.
- Dental treatment, except as the result of a covered injury.
- The repair or replacement of any artificial dental restoration.
- Expenses payable under any Workers Compensation Law or similar legislation.
- Injury sustained while riding in or on any two or three wheeled engine driven vehicle.

To Purchase Coverage
Complete the following enrollment information and send with the appropriate premium amount to United States Fire Insurance Company, Student Insurance Processing, P.O. Box 4200, Wheaton, IL. 60189.

Name of Student Enrolling _____ Date of Birth _____

Mailing Address _____

Name of Individual School _____
Please Check Appropriate Coverage:
☐ Day Care ($3.75) ☐ Summer ($3.50) ☐ CBT Program ($7.50)

Signature of Parent or Guardian _____ Date _____
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement may be guilty of insurance fraud. I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested by the Policyholder, subject to the payment of the required premium K-12 Form SNIC-HPS/2015

Health Science Education
PHYSICAL EXAMINATION

SCHOOL:	PROGRAM:

TO BE COMPLETED BY APPLICANT PRIOR TO EXAMINATION

NAME:	PHONE:	BIRTHDATE:

ADDRESS_____ No./Street
Apt. City State Zip Code

I understand that I may be asked to submit additional data.

_____
Applicant's Signature

TO BE COMPLETED BY EXAMINER

Blood Pressure:	Temp:	Pulse:	Resp. Rate:	Height	Weight

VISION SCREENING:

Right eye with glasses:	Right eye without glasses:
Left eye with glasses:	Left eye without glasses:

HEARING SCREENING:

Forced whisper at 5 feet: ☐ Pass ☐ Fail

REVIEW OF SYSTEMS: ***(+)= Positive Findings*** ***(-)= Negative Findings***

ENT		GU/Reproductive	
Respiratory		Neuro/Muscular	
Cardiovascular		Endocrine	
GI		Integumentary	

EXPLANATION OF POSITIVE FINDINGS:

Do you consider this person to be physically capable of performing the duties required in the program stated above?

Yes ☐ No ☐

Remarks:

_____

Examining Physician/Nurse Practitioner/Physician Assistant Date

_____

Address PHONE

MAN-TOUX PPD TUBERCULIN TEST* (completed within 3 months of program admission)	DATE:	RESULTS:
***If Tuberculin Skin Test Is Positive, A Chest X-Ray Must Be Done.**		
CHEST X-RAY (if required)	DATE:	RESULTS:

IMMUNIZATIONS

RUBEOLA AND RUBELLA

Please provide proof of immunity by one of the following means (shot record, titers or current vaccinations):

☐ Shot record documentation

Rubeola (Measles): 2 doses live vaccine administered on or after first birthday Date: _____ Date: _____

MMR evidence of 2 doses administered on or after 1st birthday Date: _____ Date: _____

Rubella (German Measles): 1 dose live vaccine administered on or after first birthday Date: _____

☐ Titer

Rubeola (Measles) Date: _____ Level:_____

Rubella (German Measles) Date: _____ Level:_____

If unable to document immunity through past vaccinations or through titer, please complete the following vaccinations:

☐ Vaccinations

Rubeola* (Measles) - 2 doses at least 30 days apart Date: _____ Date: _____

Rubella* (German Measles) - 1 dose Date: _____

*** MMR may be given instead of individual immunizations.**

VARICELLA (CHICKENPOX)

☐ History of chickenpox ☐ Yes ☐ No Date: _____

If no history of chickenpox, student must verify immune status with a titer.

☐ Titer (required if no history of chickenpox) Date: _____

If titer is negative, 2 doses of varicella vaccine are recommended.

☐ Vaccination (2 doses recommended) Date: _____ Date: _____

If no immunity to chickenpox, signature required.

At this time, I decline the varicella vaccinations. I understand that I do not have immunity against chickenpox and may not go into rooms with patients who have chickenpox or shingles

_____ _____

Student Signature (If Declining) Date

TETANUS	DATE:	Proof of tetanus vaccination within the past ten years must be shown through doctor's statement or "shot" record.

HEPATITIS B (Applicant may choose to have a titer completed. Vaccine recommended if titer does not show immunity).	Titer	DATE:		RESULTS:
	Vaccine (3 doses)	DATE:	DATE:	DATE:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious and potentially life-threatening disease.

_____ _____

Student Signature (If Declining) Date

_____ _____

Examining Physician Signature Date

_____ _____

Address Phone

HEALTH HISTORY

SCHOOL	PROGRAM

PLEASE COMPLETE THE FOLLOWING QUESTIONNIARE.
THE INFORMATION ON THE COMPLETED FORM WILL BE USED FOR COUNSELING PURPOSES AND WILL NOT BE USED TO DISQUALIFY ANY STUDENT FROM PROGRAM CONTINUATION.

NAME:	PHONE:	BIRTHDATE:

ADDRESS:

No./Street Apt. City State Zip Code

Have you had any serious injuries or operations within the past three years that would inhibit your ability to perform the core standards?

□ YES □ NO
If YES, please explain:

CHECK ANY OF THESE CONDITIONS WHICH APPLY TO YOU:

□ Bone injury or other problems that prohibit lifting 40 lbs.

□ Diabetes

□ Hearing problems (Surgery, hearing aid, other treatment)

□ Heart disease

□ Problems bending frequently

□ Problems pushing objects over 50 pounds

□ Seizures (convulsions, epilepsy)

□ Trouble standing or walking for long periods (4-6 hours)

□ Vision problems (glasses, surgery, color blindness or other treatment)

□ Do you have any physical or mental limitations that keep you from fulfilling the requirements of the core performance standards?

Yes_____ No_____ If yes, please explain._____

I have read the Student Information sheet and attest to the truth of my responses on this form. I will notify the school of any changes in my physical status.

Student signature _____ Date: _____

Proof of Flu Vaccine

Everyone 6 months of age and older should get a flu vaccine every season. This recommendation has been in place since February 24, 2010 when CDC's Advisory Committee on Immunization Practices (ACIP) voted for "universal" flu vaccination in the United States to expand protection against the flu to more people.

- **Flu vaccines CANNOT cause the flu.** Flu vaccines that are administered with a needle are currently made in two ways: the vaccine is made either with a) viruses that have been 'inactivated' (killed) and are therefore not infectious, or b) with no flu viruses at all (which is the case for recombinant influenza vaccine). The nasal spray flu vaccine does contain live viruses. However, the viruses are attenuated (weakened), and therefore **cannot cause flu illness**. The weakened viruses are cold-adapted, which means they are designed to only cause infection at the cooler temperatures found within the nose. The viruses cannot infect the lungs or other areas where warmer temperatures exist.
- **Flu vaccines are safe.** Serious problems from the flu vaccine are very rare. The most common side effect that a person is likely to experience is either soreness where the injection was given or runny nose in the case of nasal spray. These side effects are generally mild and usually go away after a day or two. Visit Influenza Vaccine Safety(http://www.cdc.gov/flu/protect/vaccine/vaccinesafety.htm) for more information.

FLU VACCINE

Please provide proof of flu vaccine:

Student Name:_____

Type of Immunization:_____

Date of Immunization:_____

Manufacturer of Immunization: _____

Lot Number of Immunization:_____

Expiration Date of Immunization:_____

Hillsborough County
PUBLIC SCHOOLS
Excellence in Education

Student Media Release Form

Date: _____

School: _____

Student ID Number: _____

Student Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Dear Parent/Guardian:

Throughout the school year, the media may visit your child's school to cover special events. Hillsborough County Public Schools also may wish to interview, photograph, or videotape your child for promotional and educational reasons to utilize in publications, posters, brochures, and newsletters; on the Internet, radio, or television; or for other special district events. Before your child can participate in any of the above activities, you must give your permission by signing and returning this media release form to your child's school.

☐ **I give my permission** for my child to be interviewed, photographed, or videotaped for use in school/district publications, school district productions, or for use on the Internet or by the general news media for print, broadcast, or on websites; and for his/her name to be published in school/district publications, on the Internet, or in news publications or broadcasts.

☐ **I do not give my permission** for my child to be interviewed, photographed, or videotaped for use in school/district publications, or for use by the general news media for print, broadcast, or on websites; nor for his/her name to be published in school/district publications, on the Internet, or in news publications or broadcasts.

Parent/Guardian signature: _____

Parent/Guardian name (*please print*):_____

Date: _____

STATEMENT OF CONFIDENTIALITY

The undersigned hereby acknowledges his/her responsibility under federal and other applicable law, the agreement to keep confidential any information regarding clinical facility patients, as well as all confidential information of the clinical facility. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of the clinical facility.

_____ _____

Student Name Student Signature

_____ Date _____

Parent/Guardian's Signature

(Notary Stamp)

State of Florida, County of _____ Subscribes and sworn to be a

Notary Public this _____day of _____ 20____

Notary _____

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

APPLICATION FOR PARTICIPATION

Instructional Field Trips

This form is used for recording student requests to participate in instructional field trips and the parent or guardian's permission for them to participate and travel in specified transportation. It must be on file before a student may participate.

Student Request

I, _____, am a student in _____class at _____ School.
Print Name of Student Print Name of Class Print Name of School

My parent/guardian's name is: _____
Print Name of Parent/Guardian

My home address is: _____
Print Street Address City State Zip

The intent of this voluntary statement is to form an agreement in which I pledge my compliance with the policies specified in the School District of Hillsborough County Student Handbook and to conduct myself on all field trips in such a manner as to bring honor to my school and myself in return for the privilege of being included as a participant in field trip activities.

_____ _____
Student Signature Date of Signature

Parent/Guardian Request

As parent or guardian, I request that _____ participate in the field trip to
Print Name of Student

_____ that will be conducted on _____.
Print Name of Trip Destination Month/Day/Year

I understand that transportation for the trip will be provided by

- ☐ A private automobile of a parent, teacher, and/or licensed student, none of which is under control of the School District of Hillsborough County
  AND/OR
- ☐ A regular school bus operated by the School District of Hillsborough County.
  AND/OR
- ☐ A private bus under charter to the School District of Hillsborough County.

_____ _____
Signature of Parent or Guardian Date of Signature

A copy of this form must be turned in to the office three (3) days prior to the field trip.

Distribution: Principal, Teacher
SB 60531 (Rev. 10/8/2015)

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

FIELD TRIP MEDICAL RELEASE FORM

This form is used for recording parental permission for medical and/or surgical treatment in case of medical concerns on a field trip. **A notarized signature is required for an overnight or out-of-state field trip.**

Student Name: _____ School: _____

Date of Birth: _____ Student #: _____

Location of Field Trip: _____ Date(s) of Field Trip: _____

As the parent and/or legal guardian of (*print student name*): _____, I authorize Hillsborough County Public Schools, its agents, employees, and other officers to procure and consent to any medical emergency treatment, including hospital care, to be rendered to my child by or under the supervision of a licensed health care provider. The parent/legal guardian is responsible for any fees or costs. My signature below represents consent and agreement to the matters stated above.

_____ _____
Parent/Guardian Signature *Date*

STATE OF FLORIDA, COUNTY OF _____

SUBSCRIBED and sworn to before me, a Notary Public, this _____ day of _____, 20___.

Signature of Notary: _____ Print Name: _____

Medical Insurance Company:_____ Policy #:_____

Student's Address:_____ Phone:_____

Father's Name:_____ Phone (Day):_____

Business Name (if applicable):_____ Phone (Evening):_____

Mother's Name:_____ Phone (Day):_____

Business Name (if applicable):_____ Phone (Evening):_____

Family Physician's Name:_____ Phone:_____

Physician Address (street, city, state):_____

Check any health conditions that apply (if none, leave blank). Allergies __ Asthma __ Diabetes __ Seizures __

Heart condition __ Other (please describe):_____

Medications prescribed:_____

Hospital preference:_____

NOTE: In the event of an emergency medical situation, the chaperone/teacher will call 911 and all attempts will be made to contact the student's parent/guardian regarding the emergency.

Distribution: Office, Teacher to take original on field trip