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INSTRUCTIONS

DEADLINE IS AUGUST 1ST

Instructions for creating your Immunization Record on The CastleBranch

1. Create your account by www.castlebranch.com. **Package code "WK99clinical".** Please fill out all of the necessary information.
2. Process your payment by submitting payment information.
3. Please download all necessary forms.
4. Upon completion, upload all necessary forms and documents to CastleBranch using the methods provided by CastleBranch.

Instructions for entering your Requirements to CastleBranch

1. **Measles (Rubeola), Mumps, and Rubella**: **One time with positive titer (Must upload Lab Titer Results)**
   You must have a titer with "Immune" result for Measles (Rubeola), Mumps, and Rubella. If the results of the titer are "Not Immune" or "Equivocal", then a follow up vaccination and a repeat titer 60 days later is required. Please submit proof of revaccination and results for the titer to **CastleBranch**.

2. **Hepatitis B**: **One time with positive titer (Must Upload Titer Results)**
   You must have a Hepatitis B titer with "**Immune**" result. If the results of the titer are "Not Immune" or an "Equivocal", then you must submit proof of your original series of 3 of Hep B vaccinations, then submit proof of a booster of Hepatitis B, along with a follow up titer 60 days later. ****If you do not have proof of the original series of 3 vaccinations***, then you must begin the series of three Hep B vaccines. The guidelines for the series of three are as follows: submit 1st vaccination, 30 days later submit vaccination #2, 5 months later submit vaccination #3, 60 days after the 3rd vaccination, you must receive a follow up titer. You must submit proof to **CastleBranch.**

3. **Varicella**: **One time with positive titer (Must Upload Titer Results)**
   You must have a Varicella titer with "Immune" result. If the results of the titer are "Not Immune" or "Equivocal", then a follow up vaccination and a repeat titer 60 days later is required. Please submit proof of revaccination and results for the titer to **CastleBranch**.

4. **Tetanus Diphtheria Pertussis (Tdap): One time. Must be within 10 years (Must Upload proof of immunization)**
   You must have a Tetanus Diphtheria Pertussis (Tdap) vaccination. Please supply proof from healthcare provider to **CastleBranch**.

5. **Seasonal Flu/H1N1 Annual (You may use Form Provided on website and Upload Results)**
   You must have proof of a seasonal flu shot every fall. As this is a seasonal vaccination, **you may not show proof of vaccination before Aug 1st and no later than Oct. 1st.** If you receive it too early, it will not be the current year's Influenza Vaccination and you will be required to repeat the vaccination. Your paperwork must have the following: Name, date of vaccination, site of administration (left or rt. deltoid), Lot #, expiration date, company providing vaccine, & signature of health care provider. Please submit proof of the seasonal flu shot to **CastleBranch**.

6. **Meningitis**: **One Time Only. 23 years of age or older are exempt (Must Fax, or upload proof of immunization)**
   You must have a Meningitis vaccination. Please supply proof from healthcare provider to **CastleBranch**.

7. **Quantiferron-TB Gold In-Tube test Annual (MUST BE During the month of SEPTEMBER) (You must upload Lab results)**
   You must upload lab results of a Negative result. If your Quantiferon Gold is positive, or if you have a history of a positive PPD, you will need to upload proof of a chest x-ray. The annual renewal will then come due a year from the month you originally received the Quantiferon. Please supply documentation from lab to **CastleBranch**.

8. **American Heart Association Basic Life Support for Healthcare Providers Certification, American Red Cross CPR/AED for the Professional Rescuer Certification or American Red Cross CPR/AED for LIFEGUARDS, ACLS Provider, BLS Provider, American Red Cross Basic Life Support for Healthcare Provider, ProCPR Adult.Child/Infant CPR & AED Certification**:
   2 Year Certification:
   You must upload proof of certification to **CastleBranch**.

9. **Pre-Clinical Medical History and Pre Clinical Physical Examination**: **One Time Only (Must Upload Signed, Stamped, and Dated Copy)**
   You must have the Medical History portion filled out and signed by you. The Pre-Clinical Physical Exam Form must be completed, signed, stamped, and dated by your healthcare provider, and submit to **CastleBranch**.

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10. **Acknowledgement of Essential Functions/ HIPAA: One Time Only (Must Upload Signed, and Dated Copy)**
    You must acknowledge Essential Functions/ HIPAA, and submit to **CastleBranch**.

11. **Health Insurance: Yearly (Must Upload Copy of Insurance Card or Proof)**
    You must maintain Health Insurance, either private or Widener University's. You must copy both front and back of card and submit to **CastleBranch**.

12. **FBI Fingerprint, Background Check, and Child Abuse**: **One Time Only.** Please follow instructions on CastleBranch Website.

13. **Drug Testing**: **One Time Only, unless mandated subsequently by The School of Nursing.** Please follow instructions on CastleBranch Website. Within 24-48 hours after you place your order, the electronic chain of custody form (echain) will be placed directly into your Castlebranch account. This echain will explain where you need to go to complete your drug test

14. **Consent to Video Record and Observation of Simulation, Confidentiality and Nondisclosure Agreement, Fingerstick for Blood Glucose Agreement Status & Health_Status_Report: One Time Only (Must upload Signed, and Dated Copy)** You must sign and upload to **CastleBranch**.

15. **Handbook Acknowledgement: One Time Only (Must Upload Signed, and Dated Copy)** You must sign and upload to **CastleBranch**.

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Medical Health History Form

*** All lines must be completed by the student – write no or none in spaces if applicable. ***

Last Name _____ First Name _____ Middle Name _____

Student ID Number _____ Home Street Address _____

City or Town _____ State _____ Zip Code _____

Sex: Male_____ Female _____ Self Identity _____

Date of Birth (MM/DD/YY) _____ Email Address _____

Home Phone Number _____ Cell Phone Number _____

Current Medications (prescription and OTC) _____

Allergies to medication, food, latex, environmental – please list: _____

_____

Medical History (include cardiac, hypertension, diabetes, seizures, asthma, acid reflux, orthopedic, TB, hepatitis, infectious diseases, immunosuppression, cancer or any other significant medical history) _____

_____

_____

Last breast, PAP or testicular exam date _____

Surgical history (include procedure name and date) _____

Mental Health History (include depression, anxiety, bipolar, anorexia, bulimia, OCD, ADD, ADHD, suicidal ideation / attempt, or psychiatric hospitalization) _____

_____

_____

Social History:	Caffeine	Yes____	No____	Type and amt. per day _____
	Tobacco	Yes____	No____	Type and amt. per day _____
	Alcohol	Yes____	No____	Type and amt. per day / wk / mo _____

Family Medical History (early cardiac death, hypertension, diabetes, cancer or any other significant medical history)

_____

_____

_____

This form has been completed truthfully to the best of my knowledge.

_____ _____

Student's Signature Date

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JUNIOR YEAR PRE-CLINICAL EXAMINATION

(to be completed by an MD, DO, NP, or PA)

Student Name_____

Blood Pressure _____/_____ L _____ R _____ (w/glasses)
Pulse _____ L _____ R _____ (wo/glasses)
Resp. _____

Check if Normal	Check if Abnormal	Describe Checked Abnormalities
01. _____ Nutrition	01. _____	01. _____
02. _____ Development	02. _____	02. _____
03. _____ Skin	03. _____	03. _____
04. _____ Eyes / Vision	04. _____	04. _____
05. _____ Ears / Hearing (wv @ 5ft)	05. _____	05. _____
06. _____ Nose / Sinuses	06. _____	06. _____
07. _____ Mouth / Throat	07. _____	07. _____
08. _____ Teeth / Gums	08. _____	08. _____
09. _____ Neck / Thyroid	09. _____	09. _____
10. _____ Lymph Glands	10. _____	10. _____
11. _____ Thorax / Breasts	11. _____	11. _____
12. _____ Lungs	12. _____	12. _____
13. _____ Heart	13. _____	13. _____
14. _____ Abdomen (Hernia)	14. _____	14. _____
15. _____ Back	15. _____	15. _____
16. _____ Extremities	16. _____	16. _____
17. _____ Neurological	17. _____	17. _____
18. _____ Deep Tendon Reflexes	18. _____	18. _____
19. _____ Personality / Emotional	19. _____	19. _____

Summary of significant findings in history / physical: _____

_____

Recommendations or limitations: No_____ Yes _____ (Describe) _____

_____

I have reviewed my patient's medical history and the School of Nursing essential functions of clinical practice forms. After examining_____, I find them able to participate in nursing clinical experiences with NO LIMITATIONS or limitations noted above.

Provider Signature: _____Date: _____ / _____/ _____

Provider's Name (Printed) _____

Phone Number: _____ Fax Number: _____

Address: _____

State: _____ Zip Code: _____

Office Stamp (Mandatory)

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Acknowledgement of Essential Functions for Nursing Practice

I have read the Widener University Essential Functions for Nursing Practice located in the School of Nursing Handbook located on the Widener University Website. Should I experience any change in my health status, for example, surgery, injury, or pregnancy, that could impair my ability to perform these Essential Functions, it is my responsibility to see my health care provider. Any limitations must be reported to the office of Disability Services.

Printed Name: _____

Student Signature: _____

Date: _____

Acknowledgement of Health Insurance Portability and Accountability Act (HIPAA) Minimum Necessary Criteria & Responsibility Form

I understand that my role as a member of the workforce and continued role as a member of the workforce is contingent upon compliance with all policies and rules of the Health System. In addition, I understand that I am required to keep confidential patient protected health information. I recognize and acknowledge that during the course of my participation as a member of the workforce, I may become aware of such private and confidential information. I hereby agree to keep this information confidential forever and not to use or disclose it to others, including all members of the Health System's workforce, and its entities and patients and family members, unless there is a need to know and I am otherwise authorized by the Health System, the Health system policies and procedures, the patient (for that patient's specific information) or, where appropriate, as required by law. I understand that I must comply with the Health System's policies and procedures regarding protected health information under HIPAA laws and regulations and I acknowledge that I have been trained in the appropriate uses and disclosures of protected health information as they relate to my specific workforce role.

Printed Name: _____

Student Signature: _____

Date: _____

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Consent to Video Record Simulation Experiences and Observation of Simulation Consent to Video Record

During your participation in a simulation clinical experience (SCE) at the Center of Simulation and Computerized Testing (CSCT), you will be both an active participant in simulated scenarios and an observer.
I hereby authorize the CSCT staff to video record my performance during clinical simulation experience.
I hereby authorize the School of Nursing faculty and staff to use the video recording(s) for purposes including, but not limited to: debriefing, faculty review, educational, research, public relations, advertisement, promotional, and/or fund raising activities.
I may have access to these recordings, and under no circumstances shall I share them with others through Internet sources or electronic media. Infractions of this policy shall be treated as violations of Academic Honesty/Student Code of Conduct.
Observers and Visitors
The Center of Simulation and Computerized Testing is a centerpiece of the School of Nursing and is frequently visited by educators and administrators of Schools in the design phase of a new building or renovation or in the development process for simulation experiences. Prospective students and their families also often visit the School of Nursing and may observe simulations in process. I understand that there may be individuals observing as I participate in simulation and educational activities and I hereby consent to their presence. During observations by these individuals no individual student evaluations shared.

By signing below, I acknowledge to having completely read, fully understand and agree to the above statements. I understand that this consent is applicable to all simulation and educational activities at Widener University that I may take part in from this point forward.

Print Name: _____ Date: _____

Signature: _____

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Center of Simulation and Computerized Testing
Confidentiality and Nondisclosure Agreement

I, _____, understand the significance of confidentiality with respect to information
Please type your name

concerning simulated patients and fellow students. I will abide by the Health Insurance Portability and Accountability Act (HIPAA) and the Student Code of Conduct set forth in the Widener University student handbook. I agree to report any infraction of confidentiality and nondisclosure of scenarios.

I pledge to create a collaborative and non-hostile learning environment in the Center of Simulation and Computerized Testing (CSCT). This environment will be fostered by maintaining confidentiality and nondisclosure surrounding events involving scenario performance and debriefing sessions in the lab. I understand that it is considered a violation of confidentiality and academic honesty for me to share information of another student's performance. Destructive criticism and or punitive negative discussion, either in the lab or at another location, regarding another student's performance will be considered a violation of the American Nurses

Associate Code of Ethics, which calls for respect to be accorded to all colleagues. All simulation experiences are part of the clinical course work. Evidence of unprofessional behavior will result in
disciplinary action.

I agree to abide by the rules of the CSCT and to utilize the laboratory and simulation equipment appropriately.
Guidelines:

1. **I will notify my instructor or the Director for CSCT of any medical conditions or latex allergy that may interfere with my ability to satisfactorily complete the laboratory requirements.**
2. **I will not enter the CSCT without a faculty member.**
3. **I will not eat or drink in the CSCT unless it is sanctioned by staff.**
4. **I will use the sharps containers properly, assuring they are not overfilled.**
5. **I will arrive and depart at the CSCT as designated by faculty or staff. I will log in by printing my name and providing my signature. I will not sign anyone in or have anyone sign me in, as this is an infraction of academic honesty.**
6. **I will abide by the dress code of the CSCT as stated in my course syllabus.**
7. **I will be prepared with the appropriate supplies as specified by my syllabus (i.e. watch, stethoscope).**
8. **I will place books, bags, coats etc. on the shelving by the doors of the CSCT.**
9. **I will turn off my cell phone, pager, or other electronic devices, unless it is part of the simulation, and I will avoid reading messages until after my designated time in the CSCT, as this environment is to simulate the patient care environment and such activities are not permitted.**
10. **I will not have a pen or marker near the manikins.**
11. **I will treat the CSCT as a clinical site.**
12. **I will treat the manikins and patient simulators with the same respect I afford patients in the hospital or clinical setting.**
13. **I will immediately report malfunctioning equipment.**
14. **I will not remove any equipment, computer, or supplies from the lab unless directed to do so by the Director for the CSCT, my faculty, or CSCT staff.**
15. **I will leave the lab in the same condition I found it. I will place trash and dirty linen in appropriate receptacles.**
16. **I will not discuss simulation scenarios with other classmates in other sections. I understand disclosure of these scenarios is considered a violation of the Academic Integrity policy of the School of Nursing.**

Signature _____ **Date** _____

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Clinical/Simulation Health Status Report

Name: _____ Date: _____

In accordance with the guidelines of the Clinical Simulation and Nursing Skills Laboratory Guidelines, I am notifying the School of Nursing of the following condition (s): Please CHECK

- **_____No known medical condition that will affect patient care/simulation experiences.**
- **_____Pregnancy: _____ weeks**
- **_____Health condition that may impact patient care/simulation experiences due to medication reaction and/or symptoms such as syncope, dizziness, or alteration in ability to focus.**
- **_____Other _____**
- **_____NONE**

***Environmental Allergies*: Please CHECK:_____None_____Known_____Latex Other_____**

Reaction _____

Prescribed treatment _____

Precautions to be taken _____

CHECK ONE

_____I have NO restrictions to my clinical/ laboratory activities

_____My health care provider has initiated the following restrictions:

_____

_____

_____

_____

If restrictions are indicated, the student must be cleared through University Health Services.

This information will be kept confidential. The health services will be given a copy of this form in order to be prepared for any necessitation of emergency intervention.

_____ _____

Signature Date

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INFLUENZA VACCINATION FORM
(USE OF THIS FORM IS OPTIONAL)

You may not show proof of vaccination before Aug 1st and no later than Oct. 1st

FORM MUST BE COMPLETED BY HEALTH CARE PROVIDER

- **Student Name_____Date of Birth_____**
  Please Print
- **Date of vaccination_____**
- **Site of Administration (Right Deltoid or Left Deltoid)_____**
- **LOT # of Flu_____**
- **Expiration Date _____**
- **Company providing influenza vaccination_____**
- **Signature of Health Care Provider _____**
  Signature

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HANDBOOK ACKNOWLEDGEMENT

I acknowledge that I have been informed that the School of Nursing Undergraduate Handbook can be found on the School of Nursing Office page and I acknowledge that I am fully responsible for all the information and policies contained in this document.

Student name (PRINT)_____

Student Signature_____

Date_____

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AGREEMENT TO PARTICIPATE IN SKILLS LAB PRACTICE (INVASIVE PROCEDURES)

I agree to allow a nursing student classmate or nursing instructor (for demonstration purposes) to perform the following invasive procedure on my person only under the direct supervision of the skills lab nursing instructor (licensed RN):

Fingerstick for blood glucose (diagnostic)

I understand that I may refuse to receive any of these procedures at any time by informing the skills lab nursing instructor. I understand that there will be no consequences for my refusal and alternate experiences will be provided.

_____

Print Name

_____

Sign Name **Date**