

THE SCHOOL DISTRICT OF
PALM BEACH COUNTY



MEDICAL SCIENCES ACADEMIES

CLINICAL HANDBOOK

2023-2024

MEDICAL PROGRAM

MEDICAL TEACHER CONTACT INFORMATION

STUDENT NAME



CLINICAL HANDBOOK

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PARENTAL NOTIFICATION FORM

(Please Print or Type)

Student Name: _____ Student I.D. _____

I, _____ have received the Medical Science Academy
(Print Parent/Guardian Name)

Information Packet for _____
(Print Student Name)

I understand that a Background Check will be conducted by Palm Beach County School District Police. In addition, students attending clinical classes will be required to take a Drug Screening Test. If my son/daughter does not pass the background check and/or drug screening, he/she will not be allowed to register for a clinical course and will be dismissed from the Medical Sciences Academy.

I understand that the school does not provide transportation to clinical sites; therefore, the Driving-Riding Permission Form must be signed, NOTARIZED and returned with this packet.

I understand that failure to comply with any portion of the District-wide requirements will result in re-assignment to an alternative program and/or dismissal from the Medical Sciences Academy.

I acknowledge that I have received a copy of the SDPBC Medical Sciences Academy Clinical Handbook and agree to all policies, procedures and protocols in place for clinical placements.

Parent/Guardian Signature

Student Signature

Date

Phone Number

Email

STATE OF FLORIDA, COUNTY OF _____

Sworn and subscribed before me this _____ day of _____, 20_____.

Notary Public

My commission expires: _____

Must be in the presence of a notary to sign this form

ID Provided _____

STUDENT CLINICAL ROTATION INFORMATION SHEET

Name of School: _____ Program: _____

Student Name: _____

Home Address: _____ City _____ ZIP _____

Home Number: _____ Cell Number: _____ Date of Birth: _____

Student Email: _____

Name of Parent/Guardian: _____ Relationship: _____

Contact Number: _____ Emergency Number _____

Name of Alternate
Emergency Contact: _____ Relationship: _____

Contact Number: _____ Emergency Number _____

Name of Family Physician: _____ Phone Number: _____

Address: _____ City _____ ZIP _____

Parents Email: _____

Instructor's Name: _____

Instructor's Contact Number: _____

Clinical Start Date: _____

Clinical Days (e.g. M/W): _____ Time(s): _____

Clinical End Date _____

**School District of Palm Beach County
ASSUMPTION OF RISK, WAIVER, AND RELEASE FORM**

***THIS IS A RELEASE OF LEGAL RIGHTS - - READ AND UNDERSTAND BEFORE SIGNING
(If student is under 18 years of age, a parent or legal guardian must also read and sign this form)***

Student Participant: _____ **Date of Birth:** _____

Sponsoring Entity: Approved School District Clinical Facilities

I hereby agree as Follows:

I have been informed about the name and location of the sponsoring entity for my child's clinicals

RISKS OF PARTICIPATION

I recognize that there are dangers and risks to which my child may be exposed by participating in the School District of Palm Beach County's Medical Sciences Academy. I understand my child may be exposed to accident, sickness, pandemic viruses, injury or death, criminal activity, or other circumstances beyond the control of the School Board.

I understand that The School Board of Palm Beach County (the "School Board") does not require my child to participate in the Medical Sciences Academy, but I want to do so, despite the possible dangers and risks and despite this Release.

I therefore agree to assume all of the risks and responsibilities that are in any way associated with my child's participation in the Medical Sciences Academy.

HEALTH & SAFETY

I understand and agree that the School Board and its administrators, and employees (the "Releasees") do not have medical personnel available at the Sponsoring Entity, which is the site location for my child's internship. I understand and agree that the Releasees are granted permission to authorize emergency medical treatment, if necessary, and that such action by the Releasees shall be subject to the terms of this Agreement. I understand and agree that the Releasees assume no responsibility for any injury, damage or cost which might arise out of or in connection with such authorized emergency medical treatment.

I have consulted with a medical doctor with regard to my child's personal medical needs. There are no health-related reasons or problems that preclude or restrict my child's participation in this Medical Sciences Academy. I have arranged, through medical insurance or otherwise, to meet any and all needs for payment of medical costs while my child participates in the Medical Sciences Academy.

I understand that neither the Releasees nor the Sponsoring Entity are obligated to provide transportation in connection with the Medical Sciences Academy. I understand that I am expected to carry my own automobile liability insurance coverage for my child.

STANDARDS OF CONDUCT

My child will comply with the School District's Student Code of Conduct and Code, as well as the standards of conduct for employees of the Sponsoring Entity. I waive and release all claims against the School Board that arise at a time when I am not under the direct supervision of the School Board that are caused by my child's failure to remain under such supervision or to comply with such codes and academic standards.

The School Board has the right to make changes in the format and administration of the Medical Sciences Academy. I understand that the School Board has no control over the operations or premises of the Sponsoring Entity, and that

my child will be under the supervision of a representative of that organization while my child will be participating in the Medical Sciences Academy.

ASSUMPTION OF RISK AND RELEASE OF CLAIMS

Knowing the risks described above, and in consideration of being permitted to participate in the Medical Sciences Academy, I agree, on behalf of my family, heirs, and personal representative(s), to assume all the risks and responsibilities surrounding my child's participation in the internship. To the maximum extent permitted by law, I release and indemnify the Releasees from and against any present or future claim, loss or liability for injury to person or property which I may suffer, or for which I may be liable to any other person, during my child's participation in the Medical Sciences Academy (including periods in transit).

I have carefully read this Release Form before signing it. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. This shall be governed by the laws of the state of Florida, which shall be the forum for any lawsuits filed under or incident to this Agreement or to the Medical Sciences Academy.

Signature of Student Participant

Date

Signature of Parent/Guardian (*if student is under age 18*)

Date

Consent to and Permission for Criminal Background Check and Drug Screening

I _____ acknowledge and am aware that The School District of
(Name of Parent/Guardian)

Palm Beach County's Medical Sciences Academies require participation in clinical activities during the course of the academic school year. I am also aware that the internal policies and procedures of these clinical sites ("Affiliated Agencies"), and the individual Agreements between the aforementioned Affiliated Agencies and The School Board of Palm Beach County, Florida ("School District"), require that all School District high school students assigned to one of the Affiliated Agencies for a clinical program ("Participating Students") must undergo a criminal background check and drug screening. The Participating Students may not commence their clinical activities until after they have received notice of clearance from the School District. The Participating Students must undergo:

- A criminal background check of the records maintained by the Palm Beach County Sheriff's Office and the Department of Juvenile Justice
- Drug screening by one of the facilities recommended by the Affiliated Agencies

I therefore consent to and give permission for the School District of Palm Beach County to conduct the above mentioned background checks and for my child, _____, to undergo a drug screening.

The student will submit to additional drug testing if reasonable suspicion exists after they have commenced participation in the Program. If not, the student will be removed from the Program.

Neither the School District, nor its Board Members, officers, employees, nor agents shall be liable to any student or his or her parent(s) or guardian(s) under any legal theory for any claim whatsoever based upon the results of the criminal background checks or drug screenings.

I understand that the names of students undergoing criminal background checks and drug screenings and the results of same will only be shared with appropriate school officials who have a legitimate educational interest in such information, but such information will NOT be shared with the Affiliated Agencies. I further understand that after the results of the criminal background checks and drug screenings have been obtained by an appropriate school official, the School District will notify the Affiliated Agencies of the names of the Participating Students have been cleared to participate in the clinical programs.

Parent/Guardian Signature

Date

Print Parent/Guardian Name

Student (ID) Number

Student's Full Name

School Attending

Medical Teacher

Student's Date of Birth

MEDICAL SCIENCES UNIFORM/ DRESS CODE

The Dress Code is intended to ensure that all students dress in a manner, which reflects the professionalism, enhances their safety, and projects a positive image, so as not to offend patients, visitors, and other staff members. Students are to follow these rules at all times.

❖ Uniform

- Scrubs shall be clean, pressed, and in good repair.
- Shoes shall be clean and neat.
- Appropriate undergarments shall be worn and shall not be noticeable.
- Proper PPE as required by the clinical site and/or medical teacher.

❖ Hair

- Shall be neat, clean, combed, and above the collar so as to not interfere with work or be a safety hazard.
- Hair shall not be of extreme color or style with no designs or verbiage cut into hair.
- Facial hair shall be short, trimmed, and well groomed.

❖ Students who choose to wear cosmetics are required to create a professional and business-type appearance.

❖ Fingernails

- Shall be clean, neatly groomed, and trimmed to a conservative length
- Nail polish shall be conservative – no black, neon or fluorescent colors, and no nail art jewelry, designs or decoration, etc.
- No acrylic nails are permitted as per OSHA standards

❖ No perfumes, aftershave lotions, or perfumed body lotions may be worn.

❖ Any electronic device such as cell phones or headphones may not be used while on duty.

❖ Jewelry

- Earrings shall be limited to one stud earring only per ear. Male students may not wear earrings. No other visible body piercing is permitted.

❖ Tattoos may not be visible.

My signature below confirms that I have read, and agree to abide by the student rules as listed above.

Student Name _____ Parent Name _____

Student Signature _____ Parent Signature _____

Date _____ Date _____

STUDENT CLINICAL CONTRACT

The clinical sites of the Medical Sciences Academies Education Program provide an educational experience dedicated to developing students interested in health care with the information and skills needed to make viable choices in the future. In order to maintain the high standards of the Medical Sciences Academies Education Program, the following rules and regulations have been established.

As a clinical student in this program:

- I will arrive promptly to my designated department and remain for the assigned period of time.
- I will check in and out of the clinical location with the clinical supervisor.
- I will conduct myself in accordance with the School District of Palm Beach County Code of Conduct and Workplace Rules, and will be cooperative and respectful to all school and clinical staff.
- I will exemplify a positive attitude and inspire positive behavior.
- I will notify my instructor and/or department contact of any change in my daily schedule.
- I will obey all the established rules of travel by reporting directly to the clinical site and returning promptly to school during my assigned hours.
- I will park only in designated areas at school and clinical site.
- I will dress in the required clinical uniform and wear student identification at all times while on the clinical site.
- I will hold in confidence all information or facts pertaining to patients that I might encounter in accordance with HIPAA rules.
- I will abide by the rules and policies listed in the clinical handbook, school student handbook, and the guidelines, protocols, procedures and policies of the clinical site (to include COVID-19 guidelines).

I have read the above and understand that failure to follow any of the rules/regulations will lead to dismissal from the Medical Sciences Academies Education Program.

Student Name _____ Student Signature _____

Parent Name _____ Parent Signature _____

Date _____ Date _____

DRUG SCREENING

Name of Student _____ Student (ID) Number _____

Name of Screening Facility _____

Drug Screen Results: _____ Negative _____ Positive (Results must be sent directly to the school to the attention of the medical teacher)

Teacher Verification (Signature) _____ Date _____

Teacher Name (Print) _____ School Name _____

Note: Negative results may be confirmed by a second screening, if necessary, at the discretion of the school and medical teacher.

APPROVED FACILITIES*

For Drug Screening (results will be sent directly to teacher):

- ✓ AAA Medical Compliance Testing
5350 10th Ave North, #2, Greenacres, FL 33463
Negotiated SBPBC pricing - \$25.00
- ✓ MD Now (any location)
Standard pricing – call facility for current pricing

For Physicals/Health Screening:

- ✓ Any health care facility
- ✓ Students' Primary Care Physician (recommended)

***All fees are the responsibility of the parent/student.**

AAA MEDICAL TESTING

5350 10th Ave North #2
Greenacres, FL 33463
561-313-0000

FOR MEDICAL ACADEMY STUDENTS

MONDAY through FRIDAY 8:30am to 4:15 pm
SATURDAY 9am to 11:15 am

Cost of School Drug Screen \$ 25.00

Please fill out this form prior to coming to the office

THIS IS A URINE TEST

Make sure to have a full bladder

Bring ID

Today's Date _____

Full Name (Please Print): _____

Cell Phone Number: _____

LAST 4 of SS# or full Student ID: _____ Date of Birth: _____

AAA WILL E-MAIL RESULTS TO TEACHERS

School _____ Teacher _____

MEDICAL SCIENCES ACADEMIES HEALTH SCREENING FORM

Student Name (Print): _____

Student ID #: _____ Date: _____

Influenza (Flu Vaccine), Date Given _____

Tdap/Adacel (Tetanus, Diphtheria, Pertussis), Date Given _____ OR Titer Results

T.B. Screening/PDD – *Required Yearly*

Tuberculin Skin Test _____ Negative _____ Positive (If positive provide Chest x-ray)

Date: _____

OR

_____ Documented previous positive reaction

_____ Negative Chest X-ray

Rubella/ Rubeola Immunity _____ 2 Doses of MMR (measles, mumps, rubella)

OR

_____ Positive antibodies titers

_____ Negative titer

Varicella Immunity _____ Positive history of Chickenpox

OR

_____ Varicella Vaccine

Hepatitis B _____ Hepatitis B Series

OR

_____ Declination of Vaccination

I have been advised that the **Hepatitis B vaccination is required for the clinical internship program**. I understand that due to the possible occupational training exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I am aware that I can waive the Hepatitis B requirement only by signing this Vaccination Declination Form. In that case, I continue to be at risk of acquiring Hepatitis B, a serious disease. In the future, should I decide to be vaccinated with Hepatitis B vaccine, I will provide proof of this to my instructor.

Parent/ Guardian Signature _____ Student Signature _____

I certify that on _____ I have examined the above-named student and I find him/her physically, mentally and emotionally able to participate in the Medical Sciences Academies Education Program.

Examining Physician Signature: _____ Date: _____

Name of Examining Physician (Print): _____

This is a sample DH 3040. Physician will provide this form to you.



**STATE OF FLORIDA
School Entry Health Exam**

To Parent/Guardian: Please complete and sign Part I — Child’s Medical History. State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD’S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left. *(Please explain any “Yes” answers in the space provided below.)*

1. Yes No Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes No Any other specific illness or social/emotional or behavioral problems?
3. Yes No Any allergies (food, insects, medication, etc.)?
4. Yes No Any prescription medication (daily or occasionally)?
5. Yes No Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes No Any hospitalization, operation, or major illness (specify problem)?
7. Yes No Any significant injury or accident (specify problem)?
8. Yes No Would you like to discuss anything about your child’s health with a school nurse?

To Parent/Guardian: Please explain any “Yes” answers from above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.



Signature of Parent/Guardian

Date

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child’s ability to learn in school. **(These services are recommended but not required.)**

<p>1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ Health Care Provider: _____ <i>(check one)</i> Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/></p>	<p>Please describe any corrective action for any problems detected and any accommodations required.</p>
<p>2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ Dentist: _____</p>	<p>Please describe any corrective action for any problems detected and any accommodations required.</p>
<p>3. Hearing Screening Date of Exam: _____ Results of Exam: _____ Health Care Provider: _____</p>	<p>Please describe any corrective action for any problems detected and any accommodations required.</p>



Name of Child (Last, First, Middle)	Birth Date
-------------------------------------	------------

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____
(Exam must be within one year of enrollment) Month Day Year

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed <input type="checkbox"/>	Hearing - Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
Vision - With Glasses	Right 20/_____	Left 20/_____	Failed <input type="checkbox"/>	Hearing - Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
			Referred <input type="checkbox"/>				

- Gross dental (teeth and gums) Normal Abnormal _____ Refer/Tx: _____
- Head/scalp/skin Normal Abnormal _____ Refer/Tx: _____
- Eyes/Ears/Nose/Throat Normal Abnormal _____ Refer/Tx: _____
- Chest/Lungs/Heart Normal Abnormal _____ Refer/Tx: _____
- Abdomen Normal Abnormal _____ Refer/Tx: _____
- Postural assessment Normal Abnormal _____ Refer/Tx: _____

TB risk assessment done (Please review Targeted Testing Guidelines listed below.)

This child has the following problems that may impact the educational experience:

- Vision Hearing Speech/Language Physical Social/Behavioral Cognitive

Specify: _____

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.
(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

- This child may participate fully in school activities including physical education.
- This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
<input checked="" type="checkbox"/>	____/____/____	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. Do not record administration of any TB test or related information on this form.

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

This is a sample DH 680. Physician will provide this form to you.



FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; Rule 64D-3.046, Florida Administrative Code

LAST NAME	FIRST NAME	MI	DOB (MM/DD/YY)
PARENT OR GUARDIAN	CHILD'S SS# (optional)	STATE IMMUNIZATION ID# (optional)	

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- See DH Form 150-615, Immunization Guidelines - Florida Schools, Childcare Facilities and Family Daycare Homes (July 2010) for information and instructions on form completion. Guidelines are available at: www.immunizeflorida.org/schoolguide.pdf

VACCINE	DOE CODE	Dose 1 MM/DD/YY	Dose 2 MM/DD/YY	Dose 3 MM/DD/YY	Dose 4 MM/DD/YY	Dose 5 MM/DD/YY
DTaP/DTP	A	_____	_____	_____	_____	_____
DT	B	_____	_____	_____	_____	_____
Tdap	P	_____	_____	_____	_____	_____
Td	Q	_____	_____	_____	_____	_____
Polio	D	_____	_____	_____	_____	_____
Hib	E	_____	_____	_____	_____	_____
MMR (Combined) (Separate)	F	_____	_____	_____	_____	_____
	G, H	_____	_____	_____	_____	_____
	I	Measles (dose 1)	Measles (dose 2)	Mumps (dose 1)	Mumps (dose 2)	_____
		Rubella (dose 1)	Rubella (dose 2)	_____	_____	_____
Hepatitis B	J	_____	_____	_____	_____	_____
Varicella	K	_____	_____	_____	_____	_____
Varicella Disease	L	_____	_____	_____	_____	_____
PneumoConju	N	_____	_____	_____	_____	_____

**Select appropriate box(es)
Certificate of Immunization for K-12**

Part A-Complete

- DOE Code 1: Immunizations are complete K-12 (Excluding 7th grade/middle school requirements)
- DOE Code 8: Immunizations are complete for 7th grade

I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance, as documented above.

Temporary Medical Exemption

Expiration date: _____

Part B-Temporary

Part B (For children in daycare, family daycare homes, preschool, kindergarten and grades 1 through 12 who are incomplete for immunizations in Part A). Invalid without expiration date. DOE Code 2

I certify that the above named child has received the immunizations documented above and has commenced a schedule to complete the required immunization. Additional immunizations are not medically indicated at this time.

Permanent Medical Exemption

Part C-Permanent

Part C (For medically contraindicated immunizations, list each vaccine and state valid clinical reasoning or evidence for exemption.)

DOE Code 3 _____

I certify the physical condition of this child is such that immunizations as indicated in Part C above are medically contraindicated.

Physician or Clinic Name: _____

Physician or

Authorized Signature: _____

Issued By: _____

Date: _____



MEDICAL SCIENCES ACADEMIES

CLINICAL DOCUMENTATION CHECKLIST

Student Name _____ Class _____ Period _____

Page 1

Front Page

Students Name listed _____ Instructor _____

Page 3

Parental Notification Form

Student Name / ID _____ Parent signature _____ **Notarized** _____

Page 4

Student Clinical Rotation Information Sheet

Complete with DOB _____ Email _____ Phone #'s _____

Page 5

Medical/ Accident Insurance/ Emergency Medical Authorization

Medical Insurance _____ Signed _____ **Notarized** _____

Page 6

Assumption of Risk, Waiver, and Release Form

Student signed _____ Parent signed _____

Page 8

Consent and Permission for Criminal Background Check and Drug Screening

Completed _____ Cleared by District/School Police _____

Page 9

Student Driving-Riding Permission Form

Driver Form **Notarized** _____ Student driving? YES/NO Allowed to go with others? YES/NO

Copy students DL _____ Copy of auto insurance card _____

Page 10

Uniform/ Dress Code

Student signed _____ Parent signed _____

Page 11

Clinical Contract

Student signed _____ Parent signed _____

Page 12

Drug Screening

Negative results _____

Page 14

Health Screening Form PPD date admin _____ Date read _____ (required yearly)

X-Ray(q2yr) _____ Bld draw(1X) _____ Hep B _____ Signed Parent _____

Signed MD _____ Declination of Vaccination _____

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State of Florida School Entry Health Exam – Physical Form DH3040 (2 pages)

Student must get original form from doctor. Must show MMR date, Varicella date AND that all immunizations are up to date. DH 3040/Yellow _____

Page 17

Florida Certification of Immunization – Form DH680 DH 680/ Blue _____

Flu Shot Date _____ **Declination Form** _____

BLS Card Copy _____

Teacher Signature: _____ Clinical Clearance Date: _____