NORTHLAND
COMMUNITY & TECHNICAL COLLEGE

Student Advisory Concerning Health Screening Records and Consent to Disclose

I, _____, am a student at Northland Community and Technical College who is enrolled in a Health and Human Services program (HHSP). I acknowledge that I have been informed of and understand the following:

(Print Name)

1. That Northland Community and Technical College, to protect patients, employees, students and others, and to comply with standards established by affiliated clinical healthcare providers, is requesting certain health screening information about me. The requested information includes dates of my immunization against the following diseases: measles, mumps, rubella, diphtheria and tetanus, varicella, influenza, hepatitis B, tuberculosis screening, along with CPR certification and background studies.
2. That unless an exception applies, I am not legally required to provide this information, but if I do not, I may be ineligible to participate in HHSP clinical experience or training unless I meet an exception in the policy.
3. That willful failure to provide complete and or accurate health screening information may be cause for discipline under the College Student Conduct Code. I may be asked to provide documentation to verify the health screening information I have provided.
4. That the health screening information I provide is classified as private educational data under state and federal law, and the College will maintain and otherwise handle this data in accordance with the applicable laws.
5. That the health screening information I provide will be used to determine whether I meet the health standards for eligibility to participate in clinical training that is an essential part of my HHSP. This information will be available to college faculty, administrators, clerical or professional employees who have a legitimate educational interest is access to the information in order to perform their official duties.
6. This information may also be available to instructors, administrators, clerical or professional personnel at affiliated clinical training sites if I have consented to disclosure. If I do not consent, I may not be able to participate in clinical training at that site. These sites may not disclose my health screening information to another party unless I give further consent or the site is mandated by law to report information to public health officials.
7. That information from my background studies may be shared between the Minnesota Department of Human Services and the Vendor of the National Background Study.

_____ **I acknowledge that I have been informed of and understand the above**
(Print Name) **and that my consent is valid for 12 months from the date on this form.**

Consent to Disclose: Having been informed of the College's **Policy 3310** concerning health screening information.

_____(initial), **I hereby consent to allow the College to disclose my health screening information to the affiliated healthcare site where I am assigned in order for the site to ascertain my health status to participate in clinical training.**

Signature of Student: _____ **Date:** _____

Star ID/Student ID:_____

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