College of Health
Drug/Alcohol Policy

All dental and nursing students are expected to be free from any influence of drugs and/or alcohol while in class and during all clinical/lab experiences. All dental and nursing students must undergo drug screening prior to matriculation into the clinical portion of their majors.

Additionally, the College of Health reserves the right to require any and all students accepted into its clinical programs to submit to random drug screening upon request and at any time a student is suspected of being under the influence. Failure to comply will result in immediate dismissal from the program.

If a student is suspected of being under the influence, they will be removed from class and/or lab/clinical experiences and asked to submit to drug testing within 24 hours using the procedure described below. Admission of drug/alcohol use will result in immediate dismissal from the program and referral to University Student Affairs for possible additional disciplinary action.

If the student denies any drug or alcohol use, they must undergo drug screening, at their expense using the following protocol. If the drug screen comes back negative, the student is allowed to return to class and/or clinical experiences. If the drug screen comes back positive, the results will be reviewed by the appropriate university administrator and may result in dismissal from the program.

Students have the right to appeal any disciplinary action resulting from the drug/alcohol screen.

To Be Completed by Student

I have read and understand the above policy.

Last Name	First Name	Middle Name	Laker ID

Signature	Date

University System of Georgia
Creating A More Educated Georgia

Student Applied Learning Experience Agreement

In consideration for participating in an applied learning experience (hereinafter referred to as the "A.L.E.") at any Facility where I may participate in such an A.L.E. (hereinafter referred to as the "Facility"), I hereby agree to the following:

1. To follow the administrative policies, standards and practices of the Facility when in the Facility.

2. To report to the Facility on time and to follow all established regulations of the Facility.

3. To keep in confidence all medical, health, financial and social information (including mental health) pertaining to particular clients or patients.

4. To not publish any material related to my A.L.E. that identifies or uses the name of the Institution, the Board of Regents of the University System of Georgia, the Facility or its members, clients, students, faculty or staff, directly or indirectly, unless I have received written permission from the Institution, the Board of Regents of the University System of Georgia, and the Facility.
However, the Facility hereby grants to the Institution the right to publish Institution administrative materials such as catalogs, course syllabi, A.L.E. reports, etc. that identify or uses the name of the Facility or its members, staff, directly or indirectly.

5. To comply with all federal, state and local laws regarding the use, possession, manufacture or distribution of alcohol and controlled substances.

6. To follow Centers for Disease Control and Prevention (C.D.C.) Universal Precautions for Bloodborne Pathogens, C.D.C. Guidelines for Tuberculosis Infection Control, and Occupational Safety and Health Administration (O.S.H.A.) Respiratory Protection Standard.

7. To arrange for and be solely responsible for my living accommodations while at the Facility.

8. To provide the necessary and appropriate uniforms and supplies required where not provided by the Facility.

9. To wear a name tag that clearly identifies me as a student. Further, I understand and agree, unless otherwise agreed to in writing, that I will not receive any monetary compensation from the Board of Regents of the University System of Georgia, the Institution or the Facility for any services I provide to the Facility or its clients, students, faculty or staff as a part of my A.L.E.

Unless otherwise agreed upon in writing, I also understand and agree that I shall not be deemed to be employed by or an agent or a servant of the Institution, the Regents or the Facility; that the Institution, Regents and Facility assumes no responsibilities as to me as may be imposed upon an employer under any law, regulation or ordinance; that I am not entitled to any benefits available to employees; and, therefore, I agree not to in any way to hold myself out as an employee of the Institution, the Regents or the Facility.

I understand and agree that I may be immediately withdrawn from the A.L.E. based upon a lack of competency on my part, my failure to comply with the rules and policies of the Institution or Facility, if I pose a direct threat to the health or safety of others or, for any other reason the Institution or the Facility reasonably believes that it is not in the best interest of the Institution, the Facility or the Facility's patients or clients for me to continue. Such party shall provide the other party and the student with immediate notice of the withdrawal and written reasons for the withdrawal.

I understand and agree to show proof of professional liability insurance in amounts satisfactory to the Facility and the Institution, and covering my activities at the Facility, and to provide evidence of such insurance upon request of the Facility.

I further understand that all medical or health care (emergency or otherwise) that I receive at the Facility will be my sole responsibility and expense.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this Applied Learning Agreement; and that I, or my parent and/or guardian, have read carefully and understand the above Applied Learning Experience Agreement; and that I have freely and voluntarily signed this "Applied Learning Experience Agreement".

This the _____ day of _____.

_____ _____
Participant Signature Witness Signature

Name:_____ Name:_____
(Please print) (Please print)

_____ _____
Parent/Guardian Signature Witness Signature
(if applicable)

Name:_____ Name:_____
(Please print) (Please print)

University System of Georgia
Creating A More Educated Georgia

Authorization for Release of Records and Information

TO: The Board of Regents of the University System of Georgia or any of its member Institutions (hereinafter referred to as the "Institution"), and any Facility where I participate in or request to participate in an applied learning experience (hereinafter referred to as the "Facility").

RE: _____
(Print Name of Student)

As a condition of my participation in an applied learning experience and with respect thereto, I grant my permission and authorize The Board of Regents of the University System of Georgia or any of its member institutions to release my educational records and information in its possession, as deemed appropriate and necessary by the Institution, including but not limited to academic record and health information to any Facility where I participate in or request to participate in an applied learning experience, including but not limited to the Facility (hereinafter referred to as the "Facility"). I further authorize the release of any information relative to my health to the Facility for purposes of verifying the information provided by me and determining my ability to perform my assignments in the applied learning experience. I also grant my permission to and authorize the Facility to release the above information to the Institution. The purpose of this release and disclosure is to allow the Facility and the Institution to exchange information about my medical history and about my performance in an applied learning experience.

I further understand that I may revoke this authorization at any time by providing written notice to the above stated person(s)/entities, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Confidential Records and Information".

I further agree that this authorization will be valid throughout my participation in the applied learning experience. I further request that you do not disclose any information to any other person or entity without prior written authority from me to do so, unless disclosure is authorized or required by law. I understand that this authorization shall continue in force until revoked by me by providing written notice to the Institution and the Facility, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Records and Information".

In order to protect my privacy rights and interests, other than those specifically released above, I may elect to not have a witness to my signature below. However, if there is no witness to my signature below, I hereby waive and forfeit any right I might have to contest this release on the basis that there is no witness to my signature below. Further, a copy or facsimile of this "Authorization for Release of Records and Information" may be accepted in lieu of the original.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this "Authorization for Release of Records and Information"; and that I, or my parent and/or guardian, have read carefully and understand the above "Authorization for Release of Records and Information"; and that I have freely and voluntarily signed this "Authorization for Release of Records and Information".

This the _____ day of _____.

_____ _____
Participant Signature Witness Signature

Name: _____ Name: _____
(Please print) (Please print)

_____ _____
Parent/Guardian Signature Witness Signature
(if applicable)

Name:_____ Name:_____
(Please print) (Please print)

BLOOD BORNE PATHOGEN EXPOSURE

REVIEW OF GENERAL PROCEDURE

In the event of exposure to any type of ***Blood Borne Pathogen***, these guidelines are recommended:

1. Immediately remove the substances from the area of contact with soap and water. If mucous membranes are exposed, flush the area thoroughly with water and an antiseptic agent.
2. If exposure occurs on-campus, first-aid treatment may be rendered by available and qualified health care providers in the CSU University Health Services during clinic hours. *(After hours: Please seek consultation with appropriate Faculty member to go over the* ***Blood Borne Pathogen*** *procedures)* If exposure occurs at an off-campus facility, follow the protocols of the host clinical agency, then immediately notify on-site CSU faculty member and upon return to campus proceed as follows.
3. Following first-aid treatment, report to the Office of Public Safety to complete an accident/ injury report which will be forwarded to the University Health Services for processing.
4. Review treatment options with a health care provider in the Clayton State University Health Services who will track incident and provide follow-up counseling.

TREATMENT OPTIONS AND RECOMMENDATIONS

If you are exposed to any type of ***Blood Borne Pathogen***, you have several treatment options available. Your Primary health care provider will help you decide the course of treatment right for you. If the student does not have a primary health care provider they can visit a Concentra Urgent Care facility at either the Morrow location, 1368 Southlake Plaza Drive, Morrow, GA; or the Airport North location, 3580 Atlanta Avenue, Hapeville, GA. The Clayton State University Health Services recommends you contact your primary health care provider or the public health department for all medical treatments and follow-up care. The following treatment regiment is recommended by the Center for Disease Control and Prevention (CDC):

1. HIV Post-Exposure Prophylaxis (PEP): Antiviral Medications such as ZDV (Zidovudine) and Lamivudine (3TC) or Stavudine (D4T) and Didanosine (DDI) may be used. For details call Clinicians' Hotline at (888) 448-4911 or visit the CDC: http://www.cdc.gov/ncidod/dhqp/bp.html
2. HIV Basic Treatment Regimen: Medications such as ZDV and 3TC (available as Combivir) or 3TC and D4T may be used.
3. HIV Testing: (within hours) or STAT, 6 weeks, 12 weeks, and 6 months.
4. Hepatitis A, B, C Panel; HBIG, if indicated, and HBV series if non-immune.
5. The source of exposure should be tested for HIV and Hepatitis A, B, C panel.

To Be Completed by Student

I have read and understand the above treatment recommendations related to ***Blood Borne Pathogen Exposure.***

Last Name	First Name	Middle Name	Laker ID

Signature	Date

CLAYTON STATE UNIVERSITY

STATE OF GEORGIA
COUNTY OF CLAYTON

CONSENT, RELEASE WAIVER OF LIABILITY, AND COVENANT NOT TO SUE

(READ CAREFULLY BEFORE SIGNING)

The undersigned hereby intends to voluntarily participate in a program of study through the School of Nursing at Clayton State University (herein after referred to as the Program) and acknowledges that participation in said Program, and travel to and from this Program may involve inherent risks of physical injury, including but not limited to death or loss of personal property and hereby assumes an such.

NOW, THEREFORE, the undersigned (for myself, my heirs, executors, administrators, and assigns) hereby agrees, for the sole consideration of the enrichment I expect to derive from the Program and for consideration of Clayton State University allowing my participation in the Program and/or arranging travel to and from the Program, to waive, release, hold harmless, covenant not to sue, and forever discharge Clayton State University and the Board of Regents of the University System of Georgia, and their members individually, and their officers, agents and employees from any and all claims, demands, rights, causes of action actions, judgments, costs and expenses, or other liability of whatsoever kind or nature resulting from my participation in or growing out of or in any way connected with this Program either arising before, during and/or subsequent to the Program, including but not limited to any and all, known and unknown, foreseen and unforeseen, bodily and personal injuries, including death; damage to property; and the consequences thereof.

I understand that the acceptance of this Consent, Release, Waiver of Liability, and Covenant not to Sue by the Board of Regents of the University System of Georgia shall not constitute a waiver, in whole or in part, of sovereign immunity by said Board, its members, officers, agents, and employees.

I further understand that if I elect to drive any vehicle during the Program and/or travel to and from the Program, I win be personally responsible and liable for all damages and injuries arising therefrom, to the extent that said liability, damage and/or injury is not covered by the Georgia State Tort Claims Act.

I hereby certify that I am 18 years of age or older, or my parent or guardian has signed below-, that I am suffering under no legal disabilities, and that I, or my parent and/or guardian, have read and understand the above Consent, Release Waiver of Liability, and Covenant Not to Sue carefully before signing and agree to be bound by its terms.

To Be Completed by Student

IN WITNESS WHEREOF, I have hereunto set my hand and seal this document:

_____			_____
Last Name	First Name	Middle Name	Laker ID

_____	_____
Signature	Date

College of Health
Health Insurance Policy

The Clayton State University College of Health adheres to the University System of Georgia Student Health Insurance Policy (USG-SHIP). This policy requires students in health related programs to carry proof of health insurance coverage.

I understand that it is my responsibility to:

- have proof of health insurance coverage prior to enrollment in clinical courses
- be able to produce proof of coverage on demand, both on-campus and at off-campus clinical sites
- continue health insurance coverage throughout my tenure in the BSDH/BSN program

I understand that per University System of Georgia guidelines, I will be automatically enrolled each semester in a discounted group health insurance plan:

- fees will be added to my student account each fall and spring/summer
- students with private health insurance can submit waiver; upon approval fees will be dropped from student account

To Be Completed by Student

Last Name	First Name	Middle Name	Laker ID

Signature	Date

College of Health
Statement of Academic Honesty

I have received a copy of the policy on academic honesty. I understand that I am expected to submit work that is totally my own, however, if a faculty member authorizes a group activity, I may work with other students.

I understand that I must appropriately reference all written work that is taken from the works of others. I also understand that this policy is binding on all of my work for the program whether in class testing or out of class projects, papers.

I understand that violation of this policy may lead to course failure, and/or probation, suspension or a permanent dismissal from the program.

To Be Completed by Student

Last Name	First Name	Middle Name	Laker ID

Signature	Date