# WELCOME TO BARRY TECH

* Please view the 4 documents that were handed out for reference:
  1. Clinical Experience Contract (yellow)
  2. Clinical Checklist and Timeline including Student Health History and Physical Exam (blue)
  3. Clinical Rotation Letter/Authorization wit code to order scrubs (white)
  4. Student Physical Requirement options (pink)

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Board of Cooperative Educational Services

# Clinical Rotations Overview

- Identify the specific paperwork requirements needed to attend clinical rotations.
- Develop a plan to complete all clinical rotation requirements within the required timeframe.
- Explain the potential consequences of missing clinic or being ineligible to participate.
- Feel prepared to follow the standards of professional conduct expected during clinical rotations and to apply to future employment.

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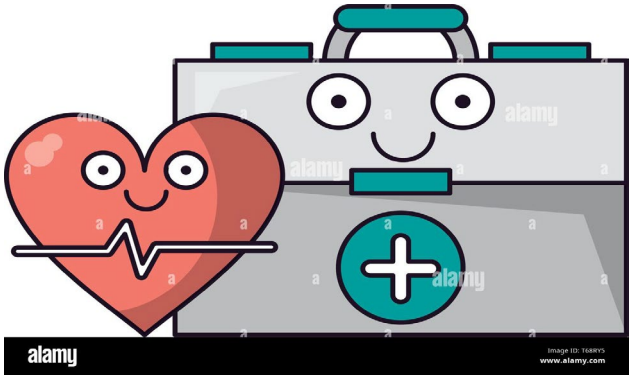
# CLINICAL EXPERIENCE CONTRACT (yellow document)

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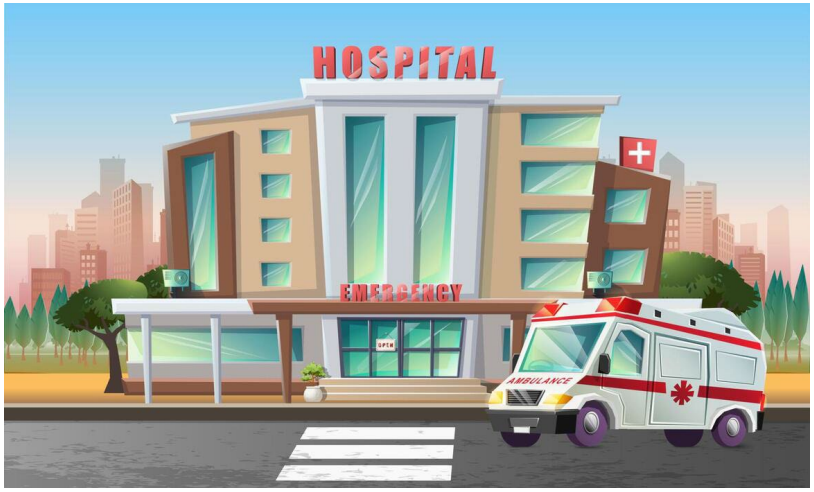
# Clinical Expectations

- Clinical internships are essential for high school students pursuing careers in the medical field
- We are guests in the partnering medical facilities
- Student and patient health and safety must remain a top priority
- All students must submit a completed **Clinical Experience Contract** before participating

Contract expectations are set by the facilities and focus on:

- Patient, staff, and student safety:
- Compliance with HIPAA privacy laws

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# Health Science Program
# Clinical Rotation

Students in the Health Science programs will participate in a required in-patient clinical rotation


* Clinical experience allows students to practice hands-on skills and explore future career paths.

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# Important Clinical Eligibility Information

* Per NYS Department of Education:
  * Lecture and classroom-based teaching
  * In-person skills lab
  * Hands-on clinical at a work-related facility
  * Must complete required hours to take certification exam

* Mandatory physical exam within 1 year needed to attend clinic.

If you need assistance finding a provider:

Contact the school nurse at

(516) 622-6819 for a list of clinics.

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# PROFESSIONAL APPEARANCE

* UNIFORM-SCRUBS AND SHOES
* HAIR
* MAKE-UP
* NAILS
* JEWELRY, EARRINGS, PIERCINGS
* NO STRONG SCENTS
* NO GUM
* NO SMOKING OR VAPING

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# CLINICAL READINESS

* GOOD STANDING
* NO ELECTRONICS
* PROFESSIONALISM
* BEHAVIOR IN CLINIC, CLASSROOM, BUS

# CLINICAL CHECKLIST AND TIMELINE (blue document)

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# Checklist for Paperwork is due on September 4, 2026

**Checklist for Paperwork DUE on September 4th**

☐ Physical completed after 06/01/2025

☐ Physical form/paperwork completed (front and back / no "see attached")

☐ Immunization records

☐ Tetanus shot (within 10 years)

☐ Flu Shot (current year or subject to wearing a mask)

☐ Hemoglobin & Hematocrit (lab results containing normal ranges)

☐ MMR Titers (lab results reflecting positive immunity or booster)
- ☐ Measles
- ☐ Mumps
- ☐ Rubella

☐ Varicella Titer (lab results reflecting positive immunity or booster)

☐ Tuberculosis (negative results)

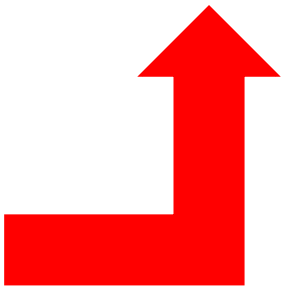
☐ QuantiFERON (lab results containing normal ranges) (RECOMMENDED OPTION)

OR

☐ PPD (this option requires up to 4 doctor visits within a specific time frame)
- ☐ PPD 1 Date (at physician) _____
- ☐ PPD 2 Date (within 90 days at the start of clinic) _____

**Common Issues**

Paperwork will need to have lab work included!



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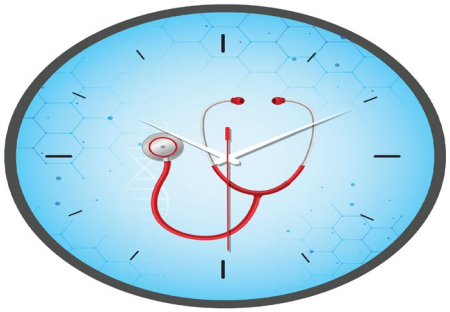
# Timeline: Make appointment ASAP Due 9-4-26



- Clinical Clearance not regular physical
- Titers are required showing lab results
- Make sure form is signed and stamped by physician

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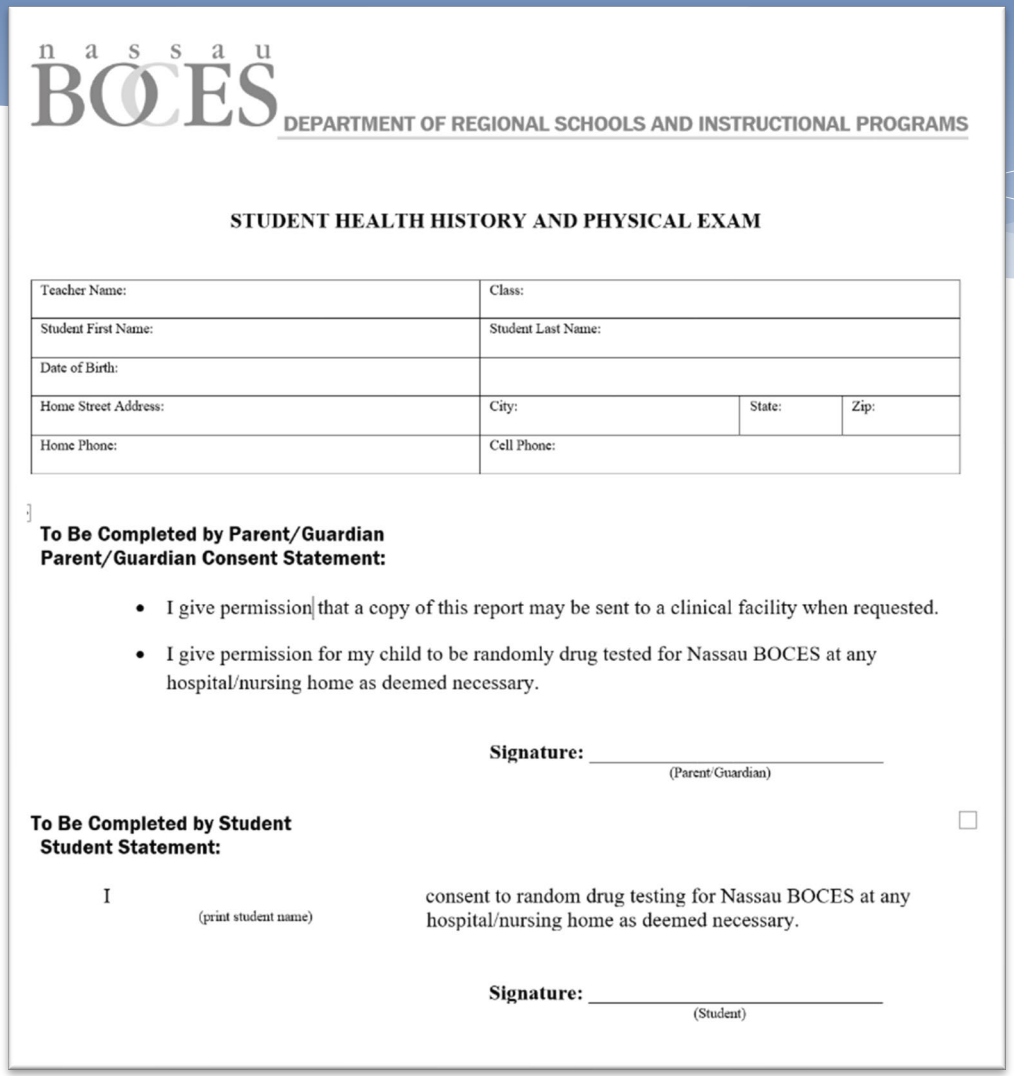
# Forms are due by September 4, 2026



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DEPARTMENT OF REGIONAL SCHOOLS AND INSTRUCTIONAL PROGRAMS

**STUDENT HEALTH HISTORY AND PHYSICAL EXAM**

| | | | |
|---|---|---|---|
| Teacher Name: | Class: | | |
| Student First Name: | Student Last Name: | | |
| Date of Birth: | | | |
| Home Street Address: | City: | State: | Zip: |
| Home Phone: | Cell Phone: | | |

**To Be Completed by Parent/Guardian**
**Parent/Guardian Consent Statement:**

- I give permission that a copy of this report may be sent to a clinical facility when requested.
- I give permission for my child to be randomly drug tested for Nassau BOCES at any hospital/nursing home as deemed necessary.

**Signature:** _____
(Parent/Guardian)

**To Be Completed by Student**
**Student Statement:**

I _____ consent to random drug testing for Nassau BOCES at any hospital/nursing home as deemed necessary.
(print student name)

**Signature:** _____
(Student)

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## STUDENT HEALTH HISTORY AND PHYSICAL EXAM

| Student First Name: | Student Last Name: | Date of Birth |
|---|---|---|
| | | |

**To Be Completed by Physician:** **Date of Exam: __/__/__**

### Medical History

Check if any of the following pertain to the student. All items checked MUST have current status and treatment explained.

| | | |
|---|---|---|
| _____ Seizure Disorder | _____ Thyroid disease | _____ Diabetes |
| _____ Asthma | _____ Scoliosis | _____ Hearing Loss |
| _____ Kidney Disease | _____ Hepatitis | _____ Rheumatic fever |
| _____ Heart condition | _____ Mental illness | _____ Orthopedic problems |
| Gynecological problems | Hypertension | Tuberculosis |

Explanations: _____

### Allergies

Drug allergies:

Food allergies:

### Medication

Is the student taking any medication at the present time? ○ No ○ Yes
If yes, please specify:

### Physical Examination

| | | | | |
|---|---|---|---|---|
| Height: | Weight: | Blood Pressure: | Pulse: | Respirations: |
| Vision: | Corrective Lenses: | ○ Yes ○ No | | |
| Skin: | | Musculoskeletal: | | |
| Thyroid: | Nose: | Throat: | Lymph nodes: | |
| Neurological, speech, tremors, reflexes: | | | | |
| Physical abnormalities: (describe) | | | | |

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| Student First Name: | Student Last Name: | Date of Birth |
|---|---|---|
| | | |

**To Be Completed by Physician** **Date of Exam: __/__/__**

| ***Mandatory*** | **Date** | **Notes:** |
|---|---|---|
| **Influenza shot** | __/__/__ | |
| **QuantiFERON-TB Gold** (QFT) | __/__/__ | QFT **OR** 2 PPDs are required within below time frame *For NUMC ONLY – if you attend clinic last year, you are only required to get 1 PDD this year but must attach last year's PDD results. .* |
| ***Or*** | | |
| PPD | __/__/__ | Must be done after 7/01/24 |
| 1st PPD result ○Negative ○ Positive | | If positive, Chest X-ray report required. |
| 2nd PPD | __/__/__ | Must be done after 8/15/24 |
| 2nd PPD result ○Negative ○ Positive | | If positive, Chest X-ray report required. |
| **Diphtheria/Tetanus** | __/__/__ | Must be within 10 years |
| **Hepatitis B1** | __/__/__ | It is highly recommended that all students be vaccinated for Hepatitis B |
| **Hepatitis B2** | __/__/__ | |
| **Hepatitis B3** | __/__/__ | |
| **COVID-19** | __/__/__ | |
| | | |
| | | |

### Mandatory Titres & Laboratory Results

Please document results from the following and attach lab reports. If the titres do not show immunity, please provide proof of a booster shot. **Please note:** For all students/instructors *attending clinic for the 1st time*, Titre Blood Tests are mandatory. For students/instructors returning to clinic for a 2nd year titre blood tests *do not* have to be repeated, **but results and lab reports must be resubmitted**. Please attach copy of immunization record.

| | Date: | Results: | Booster Vaccine *(if needed)* |
|---|---|---|---|
| Hemoglobin & Hematocrit | __/__/__ | | |
| Routine Urinalysis | __/__/__ | | |
| Rubeola Titre | __/__/__ | | |
| Rubella Titre | __/__/__ | | |
| Mumps Titre | __/__/__ | | |
| Varicella Titre | __/__/__ | | |

**Examining Physician's Statement:** The above named student can assume, without any limitations, classroom and clinical assignments. He/she is free at this time for any habituation or addiction to alcohol or drugs that may be a potential risk to Hospital Patients or Nursing Home residents.

| **Physician Signature and Stamp** | |
|---|---|
| Physician Name (print) : | Date: |
| Street Address: | |
| Telephone: | |

**Attach Lab Results:** ○ Rubeola Titre ○ Rubella Titre ○ Mumps Titre ○ Varicella Titre ○ Documentation of booster immunization (only for low immunity titers) ○ Chest X-Ray (only if positive PPD result)

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# Helpful Information

### TB Clearance Process

- You may take the QuantiFERON TB GOLD (QFT) blood test after June 1, 2026.

### Titers

- Titers show if a student is at risk for communicable diseases.
- Doctor must: Record titer test results and attach the lab report for each test

### Flu Shot

- Flu shot is **strongly encouraged**.
- Without proof of flu shot, student is **required to wear a mask** daily at clinic.
- Students **will be required** to wear a mask or face shield.

### COVID-19

- CDC/DOH guidelines may change.
- Currently: COVID-19 vaccination is **not required** for clinic placement.

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# CLINICAL ROTATION LETTER / AUTHORIZATION (white document)


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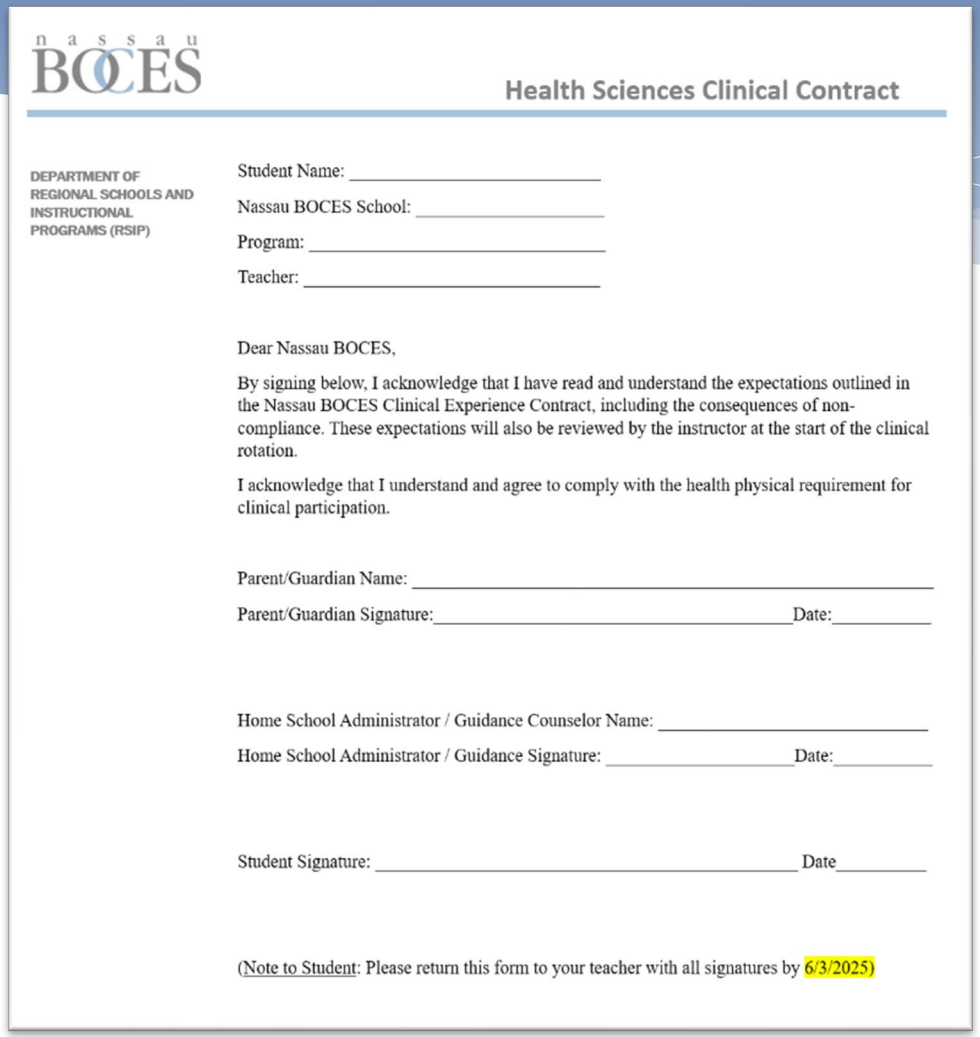
# Agreement form due on 6/4/2026



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## Health Sciences Clinical Contract

DEPARTMENT OF REGIONAL SCHOOLS AND INSTRUCTIONAL PROGRAMS (RSIP)

Student Name: _____

Nassau BOCES School: _____

Program: _____

Teacher: _____

Dear Nassau BOCES,

By signing below, I acknowledge that I have read and understand the expectations outlined in the Nassau BOCES Clinical Experience Contract, including the consequences of non-compliance. These expectations will also be reviewed by the instructor at the start of the clinical rotation.

I acknowledge that I understand and agree to comply with the health physical requirement for clinical participation.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Home School Administrator / Guidance Counselor Name: _____

Home School Administrator / Guidance Signature: _____ Date: _____

Student Signature: _____ Date _____

(Note to Student: Please return this form to your teacher with all signatures by 6/3/2025)

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# HEALTH CARE SKILLS

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# Questions

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