LEBANON COUNTY CAREER AND TECHNOLOGY CENTER

833 METRO DRIVE • LEBANON, PENNSYLVANIA, 17042 • TELEPHONE: 717-273-8551
FAX: (717) 279-7520 • www.lcctc.edu

June 2023

Dear Parent or Guardian:

On behalf of the Lebanon County Career and Technology Center (LCCTC), we would like to welcome your student to the Health CareersTechnology program for the 2023-2024 school year.

Students in the Health Careers Technology will be expected to purchase and/or complete the items on the attached sheet(s). All uniform purchases, if applicable, must be made with Major League Screen Printing. They can be contacted at 717-270-9511, or you may use the LCCTC link from www.lcctc.edu and use the "Uniform" link at the top of the page. Students are expected to have all necessary items as listed on the attached forms, on the first day of school.

Please plan to attend the event below to obtain the following valuable information regarding the LCCTC: student schedules, attendance and grading policies, curriculum, classroom rules and procedures, lunch information, college credit opportunities, parent portal, etc. A reminder letter will be mailed concerning the Parent Orientation in mid-August.

Important Dates

August 23, 2023 at 6PM	Back to School Event
August 28, 2023	First Day of School

Please contact us at 273-8551 ext. 2170 for Mrs. Mattis or ext. 2114 for Mrs. Garrett if you have any questions. Email addresses are lmattis@lcctc.edu, and bgarrett@lcctc.edu respectively. We look forward to working with you to prepare your student for post-secondary education and/or a career in the health careers field.

Sincerely,

Lori Mattis, MEd., BSN, RN
Health Careers Technology Instructor

Beth Garrett, RN
Health Careers Technology Instructor

Attachment(s)

1st Year

REQUIRED DOCUMENTATION/EQUIPMENT FOR THE HEALTH CAREERS TECHNOLOGY/PATIENT CARE TECHNICIAN (PCT) PROGRAM

Checklist

_____ **Shadow Experience Requirements:**

1. **Tuberculosis: Unpaid Interns have three options to provide Tuberculosis results:**
   OPTION 1: 1-Step Tuberculin Skin Test/PPD within 12 months of the start of internship; provide results. If history of positive PPD, answer following questions **and** provide copy of check x-ray results within the last 12 months.
   - Do you have any current symptoms (persistent cough, fever, night sweats, etc)? _____
   - Did you do INH treatment? _____

   OPTION 2: **QuantiFERON Gold** performed within 3 months of the start of internship; provide results.
   OPTION 3: T-spot test performed in within 3 months of the start of internship; provide results.

2. **Chicken Pox Vaccination** (Varicella): provide documentation of 2 placement dates or positive titer results. **NOTE: We will not accept "had disease" as documentation.**

3. **MMR Vaccination** (Measles, Mumps, Rubella): provide documentation of 2 placement dates or positive titer results. **NOTE: We will not accept "had disease" as documentation.**

4. **TDAP** (Tetanus, Diphtheria & Pertussis): provide documentation of one (1) adult dose after age 11-12.

5. **Hepatitis B Vaccination**: provide documentation of placement dates or positive titer results.
   NOTE: Hepatitis B is the only vaccination that is not mandatory for internships. It is recommended that you have the vaccine, if you will be working in a clinical area with any potential of blood or body fluid exposure. If you have not had the vaccination series or your Hepatitis B titer results were non-reactive or negative and you wish to **decline receiving the vaccine, please sign below**. By signing below, you acknowledge that you are aware of the risks involved with not receiving the vaccine and declining the Hepatitis B vaccines.

   Intern Signature: _____

6. **Flu Shot**: WellSpan Health requires a mandatory flu vaccination when an Unpaid Intern is completing their internship from October 1st through April 30th. **NOTE: The end of flu season may be extended based on CDC/Health Department requirements.**
   - Proof of flu vaccination, which includes location administered, date of administration, lot number and expiration date.

7. **COVID-19 Vaccination:** student must either **submit proof** of being fully vaccinated against COVID-19, with either two-doses of a two-dose vaccine or one dose of a one-dose vaccine

8. Copy of a physical within the last year.

_____ **Shadow Experience:**

- **Students will be responsible to provide their own transportation to and from the shadow site**

Dress Code Policy
Health Careers Technology/PCT

Appearance

Working in the healthcare profession requires critical thinking, coordination and strength. The health care worker also needs to maintain a neat and clean appearance. Good personal hygiene and a well-groomed appearance are two requirements of the Health Careers Technology/PCT Program. The following are guidelines for participation in this course:

Dress Code

You are required to be in uniform daily.

1. **Uniform**:
   - Uniform tops and pants are required to be worn daily
   - Must be cleaned, pressed and in good repair.
   - Must fit properly.
   - Students must arrive and leave in full uniform.
   - Any shirt worn under the uniform top must be solid black, white, grey or navy blue.
   - *NO PRINTED SHIRTS OR HOODIES CAN BE WORN UNDER THE SCRUB TOP
   - If student wearing a warm-up jacket, a scrub top must be worn underneath the jacket.

2. **Shoes:** All white leather sneakers or nursing shoes
   - **No sandals, clogs, boots, canvas sneakers or Crocs**
3. **Socks**
   - Socks must be worn with shoes at all times
4. **Jewelry:**
   - Watch with a second hand.
   - No Smart watches will be permitted.
   - Only one stud earring per ear.
     - No hoops, dangles
   - No facial piercing will be permitted
     - This includes the tongue.
   - No necklaces, bracelets or rings
5. **Hair:**
   - Hair must be worn up and away from the face.
   - Hair is to be groomed prior to the arrival of school.
   - Hair is to be a natural color: No unusual hair color is accepted. (I.E. blue, purple, red etc…)
6. **Make-up:**
   a. Clear nail polish may be worn
   b. Nails short and well-groomed
   c. No artificial, acrylic, or gel nails
7. **The classroom is cold so bring a uniform lab warm up jacket or uniform issued fleece.**
   a. No outside jackets, hoodies or sweatshirts are to be worn in classroom

8. Students will be expected to be in full uniform on the first day of school. Uniforms must be obtained through the school's uniform provider:

Major League, Screen Printing, 19 S.5th Ave, Lebanon, PA 17042
Phone: 717-270-9511
Email: www.mlspe.com or via the school's website:
www.lcctc.edu and click on the tab "Uniforms," then choose then chose "Health Careers Technology" (along the left hand side of the screen)

*This dress code has been developed to enable you to be properly groomed when on the job as a health care worker. These specific requirements are to be met while in this program.
It is vital that you are in proper uniform daily. Failure to do so will result in a lowering of your grade.

- **You will not be allowed to work on procedures if the dress code is not followed.**
- **Daily work ethics point deductions will be given for improper uniform.**

Dress Code Policy Signature Page:

**Please sign and return to instructor

We have read and understand the Dress Code Policy

_____	_____	_____	_____
Student Signature	Date	Parent/Guardian Signature	Date

_____	_____
Print Student Name	Print Parent/Guardian Name

Health Careers Technology
Five P's of Success!

Prompt

- ✓ Always plan to be early to be on time!
- ✓ Assignments turned in on time
- ✓ If absent: report off by calling or emailing respective instructor: LCCTC 273-8551 ext. 2170 lmattis@lcctc.edu for Mrs. Mattis or ext. 2114 bgarrett@lcctc.edu for Mrs. Garrett prior to 9:00am

Prepared

- ✓ In Uniform
- ✓ Materials, tools, devices, books
- ✓ Assignments completed

Polite

- ✓ Greet others with respect
- ✓ Show consideration of others

Professional

- ✓ Teamwork mentality
- ✓ Support Peers Success
- ✓ Do your Part
- ✓ Take Ownership

Positive

- ✓ Have a "can do" attitude
- ✓ Work towards goals

ATTENDANCE

Due to the nature of the program requirements, attendance and punctuality are very important. Appointments should be scheduled during non-school hours.

- Students with 10 or more absences or tardies will be ineligible to participate in shadow experience and/or other classroom activities.
-

*Failure to follow the five "P's" of success will result in work ethic grade deductions.
*An 80% or above overall average must be maintained for any student to participate in any outside activities. Including: field trips, HOSA events, shadowing, clinical etc.
* Any student with disciplinary referrals resulting in suspension will automatically be ineligible to participate in any clinical experiences, Shadow opportunities, field trips or extra-curricular activities. This includes the immediate removal of the student holding a HOSA officer position.

Five "P's" of Success Signature Page:

Please sign and return to instructor:

We have read and understand the five "P's" of Success and understand that all school rules will be followed within the HCT/PCT classroom as stated in the CTC student handbook

_____	_____	_____	_____
Student Signature	Date	Parent/Guardian Signature	Date

_____	_____
Print Student Name	Print Parent/Guardian Name

Safety Pledge

Directions: Read and complete the student safety pledge form by filling in the blank spaces. Return the signed form during the first week of school.

I _____, a student in the Health Careers Technology/Patient Care Technician Program, will be using health related equipment as part of my training. It is understood that each student will be given proper instruction, both in the use of the equipment and in the correct safety procedures concerning the equipment before being allowed to operate the equipment. The student must assume responsibility for the following safe practices; therefore, we ask that the followings the safety pledge:

- ***I promise to follow all safety rules associated with the program.***
- ***I promise never to use any equipment without first having permission from the instructor***
- ***I will not use a piece of equipment unless I have had proper instruction on the use***
- ***I will report any damaged equipment, accident, or injury to the instructor immediately.***

Thank you,

Lori Mattis M.Ed., BSN, RN
Beth Garrett, RN
Instructors

Safety Pledge Signature Page

Please sign and return to instructor:

We have read and understand the Safety Pledge:

_____	_____	_____	_____
Student Signature	Date	Parent/Guardian Signature	Date

_____	_____
Print Student Name	Print Parent/Guardian Name

Cell Phone/Computer Policy

Health Careers Technology/Patient Care Technician program wants to provide a learning rich environment. Therefore, all cell phones, personal devices (ipads, computers, smart watches etc..) are prohibited in the classroom. Each student is given access to a computer for use in the classroom and will not use any outside devices, including home school issued ipads/computers. All cellphones will be placed in a secure location within the classroom and students will be forbidden to use their personal cellphone at anytime during the class. Our contact information is listed below if there is an emergency and you need to contact the student during school hours.

Mrs. Mattis

lmattis@lcctc.edu

717-273-8551 Ext. 2170

Mrs. Garrett

bgarrett@lcctc.edu

717-273-8551 Ext. 2114

Cellphone Policy Signature Page:

Please Sign and return to instructors

We have read the cell phone/computer policy and agree to the policy.

_____	_____	_____	_____
Student Signature	Date	Parent/Guardian Signature	Date

_____	_____
Print Student Name	Print Parent/Guardian Name

Emergency Contact

Parent/Guardian Name: _____

Parent/Guardian Home Phone Number: _____

Parent/Guardian Cell Phone Number:_____

Parent/Guardian email Address: _____

Alternate Contact: _____

Alternate Phone Number: _____

Student Name: _____

Student Cell Phone Number: _____

Student email Address: _____

Any important information you would like to share with instructor: (i.e.: allergies to foods, emergency medical problems (asthma, seizures….)

_____

_____

pennsylvania
DEPARTMENT OF HEALTH

Private or School

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before

PHYSICAL EXAMINATION **student's exam. Take completed form to** Bureau of Community Health Systems **OF SCHOOL AGE STUDENT appointment.**
Division of School Health

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		

HEART/LUNGS: *Has the student...*	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student…*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP**

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

☐ Medical Date Issued:_____ Reason: _____ Date Rescinded:_____

☐ Medical Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

Health Careers Technology

Item	Required/Optional (R or O)	Cost
Fingerprinting (Senior Only)	**R**	**Fingerprinting: $23.25**
10 Panel Drug Test (Senior Only)	**R**	**Approx. $50.00**
Physical	**R**	**Approx: $30.00**
TB Test	**R**	**Approx: $30.00/Each**
Hepatitis B Vaccine	**O**	**??**
Flu Vaccine	**R**	**??**
Covid Vaccination	**R**	**??**
Uniforms	**R**	**Approx. $70.00**
Watch with a Second Hand	**R**	**Approx: $20.00**
Shoes	**R**	**Approx: $50.00**
Patient Care Technician Certification Exam (Senior Only)	**O**	**$122.00**
HOSA: Future Health Professionals Dues	**R**	**$20.00**
Dean Vaughn Workbook-one time only	**R**	**$30.00**
Patient Care Technician Workbook-one time only	**R**	**$45.00**