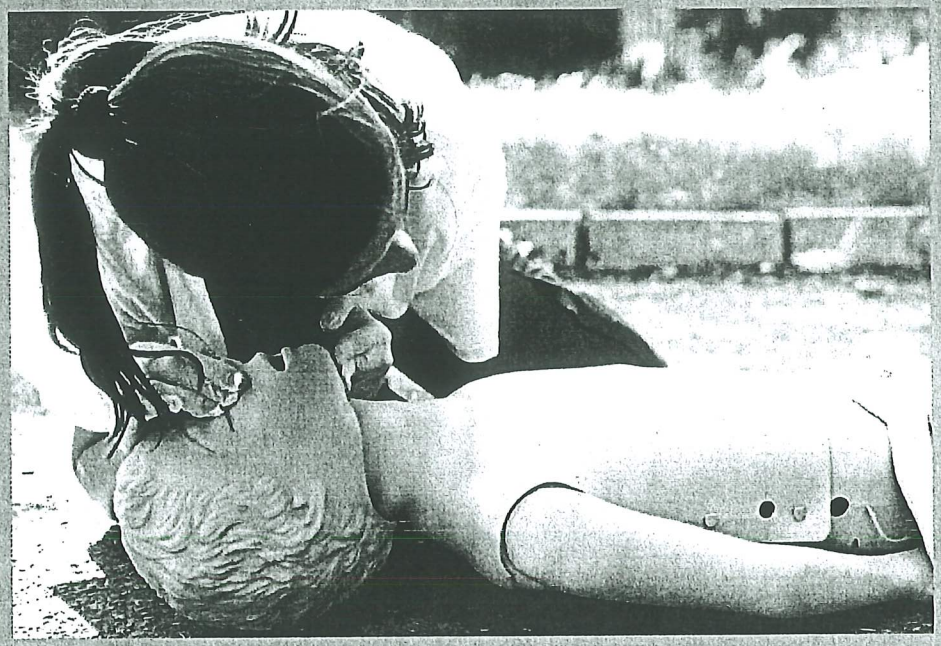
SUMMER SESSION

CPR FOR ACCELERATED CNA STUDENTS



August 5th: 4:00 PM-8:00 PM

August 6th: 8:00 AM-12:00 PM

1:00 PM-5:00 PM

August 7th: 12:30 PM-4:30 PM

Space is limited to 24 students per class

Call 815-838-6941 to Reserve a Space

Price is $30

ACCELERATED CNA CLINICAL RULES AND GUIDELINES

Rule #1 Fingernails must be natural and short in length.
Elderly skin is fragile, and extreme care is needed to prevent injury. Nails should be no longer than ¼ inch from the edge of the nail plate. Per CDC guidelines, any artificial nail product, including clear or colored fingernail polish on natural or artificial nails, is prohibited in the clinical setting.

Rule #2 No jewelry may be worn at the clinical site.
To ensure resident and student safety, you may wear only a wristwatch with a second hand. NO APPLE OR SMART WATCHES. No jewelry includes: all earrings, rings, necklaces, and any facial or visible body piercings. An exception will be made for medical alert jewelry, and religious/cultural jewelry with documentation.

Rule #3 Proper clinical attire is required for all clinical sessions.
The clinical uniform conveys a professional appearance and consists of a wrinkle-free scrub top and scrub pants, clean socks and clean white leather/vinyl shoes. All visible tattoos must be covered. A plain white, navy, or black shirt may be worn under the scrub top. **NO CELL PHONES ARE ALLOWED IN THE CLINICAL AREA.**

Rule #4 Cologne, aftershave or any grooming product with a scent is <u>not</u> permitted to be worn at the clinical site.
Strong scents are a health risk to those with allergies and sensitivities and thus need to be avoided at the clinical site.

Rule #5 Paperwork completion, including physical forms and tuberculosis screen, is due on the eleventh day of Wilco Attendance.

All paperwork must be completed and turned in prior to the start of clinical. This paperwork includes, but is not limited to, COVID-19 testing consent and Emergency contact forms. All physicals and tuberculosis testing must be done before clinical begins–there are NO EXCEPTIONS for not having this completed. Failure to have this completed will result in being ineligible for clinical and withdrawal from the accelerated program.

Rule #6 Attendance is expected for clinical and classroom

Students will be given a clinical schedule prior to starting clinical. This schedule will include both weekly attendance and long day attendance. (There will be two eight-hour days and two six-hour days; some may occur on weekends or days of non attendance). Students are expected to check dates and ensure that the selected schedule does not interfere with previously planned events. Students must inform the instructor of conflicts at the time of receiving their schedule, and the instructor will accommodate based upon availability of dates.

Students having more than **three unexcused absences for the first semester in the classroom portion will be removed from the clinical portion & will not be eligible for the State Certification Exam.** Exceptions to this rule will be granted for court dates, 3 days for funerals, or medical absences. In these cases the absences would not be counted against attendance if **official appointment documentation** is provided to the Wilco Instructor and Administration within 7 days of absence.

To meet State requirements, any clinical absence that is approved by the instructor and Wilco Administration **MUST** be made up by the student by the end of the semester. The cost for completing the make-up clinical is $20 per hour. After four (4) hours of clinical absences, the student will be subject to withdrawal from the clinical rotation and ineligible for state certification.

In the event an instructor is unable to attend a clinical session, every attempt is made to notify students of the cancellation. **If a student arrives at the clinical site and no instructor is present, the student is to call Wilco for further instruction. 1–815-838–6941.**

Rule #7 Behavior that is unbecoming of a healthcare provider will not be tolerated and will result in additional consequences, including, but not limited to, removal from the clinical rotation of the course.

- Aggressive (verbal, physical, emotional) behavior at Wilco, the home school, or in the community. This includes bullying and harassment behaviors.
- Under the influence or in possession of drugs, alcohol, or any illegal substance or illegal paraphernalia at Wilco, the home school, community, or at clinical
- Any violations of resident, instructor, or student privacy, including but not limited to: social media, texting, e-mail, or verbal communication. Absolutely no cell phones are allowed in the classroom, lab, or clinical setting.
- Placing a resident in emotional/physical jeopardy or repeatedly disregarding the policies of the clinical facility.

Rule #8 An average of 80% is expected in the classroom, lab, and clinical aspects of the course.

An 80% average must be maintained in all aspects of the class to remain eligible for clinical instruction and to qualify for the State Certification Exam. The first evaluation will be done at the end of the first module (approximately halfway through the first quarter). If students do not satisfactorily meet the requirements before or after the first module, they will be moved into a traditional CNA program at WILCO. Students may be moved into a traditional CNA course for poor attendance, inability to maintain an 80% average, or poor clinical performance at any time after the first module.

Students removed from clinical practice may continue in the theory portion of the class and receive high school credit upon receipt of a passing grade.

Violation of any of the above clinical rules may result in the student sitting out of clinical practice for that session and receiving a clinical grade of zero. Each missed clinical session must be made up at the cost of $20/hour. Makeup sessions are scheduled according to instructor availability and the student must attend the session that they are assigned.

WILCO AREA CAREER CENTER

500 Wilco Blvd
Romeoville, IL 60446

PHYSICAL EXAM FORM

To be completed by student:

Name_____ Home School_____

Address_____
Street City State Zip

Phone #_____

E-mail address _____

Birthdate_____ Age_____

Person to notify in case of emergency:

Name_____

Phone#_____

Relationship_____

Family Physician_____

Phone_____

Address_____

Name _____

To be completed by physician:.

PHYSICIAN: In the section below, denote whether area is within normal limits (WNL) or abnormal. Record details in the remarks section.

WNL	ABNORMAL	
_____	_____	General Appearance
_____	_____	Eyes (Include lids, pupils, fundi, EOM)
_____	_____	Nose
_____	_____	Mouth
_____	_____	Throat (Include pharynx, tonsils)
_____	_____	Teeth and Gums
_____	_____	Neck (Include carotids and thyroid)
_____	_____	Lymph Nodes (cervical axillary, inguinal, epitrochlear)
_____	_____	Chest and lungs
_____	_____	Heart (Size, rhythm, murmur, quality of tones, thrill)
_____	_____	Abdomen (appearance, liver, spleen, scars, mass, tenderness)
_____	_____	Hernia (umbilical, inguinal, femoral, incisional)
_____	_____	Extremities (Feet, edema, pulses, ROM, deformity)
_____	_____	Skin
_____	_____	Rectal
_____	_____	Pelvic
_____	_____	Back (attention to list, pelvic, tilt, scoliosis, ROM)
_____	_____	Neurological (Include reflexes)

Explain any checks in the abnormal section. (Note asthma or diabetes)

Student is able to participate in all aspects of the course (clinical included) without restrictions.

Physician signature: _____ Date: _____

Physician name printed: _____

_____

Street Address City State Zip Code

Phone # _____

Name _____

Immunizations:

Tuberculosis skin test: (2-step Mantoux)

TB Tine test is not accepted

#1. Date given: _____ Date read/reaction: _____ Signature _____

#2. Date given: _____ Date read/reaction: _____ Signature _____

Use above form or attach copies of TB test administration

Documentation of a 2 Step TB Mantoux test is required prior to the start of the clinical rotation. The second Mantoux test must be administered within 7-21 days of the first test, if the reaction to the initial test is negative. A single step Mantoux will only be accepted if proof of a 2 step Mantoux done within the past year is attached to this form. If a student has a recorded positive Mantoux, a chest x-ray is required.

*Reaction to test should be read within 48-72 hours by the administering facility.

STUDENT CONSENT FOR COVID-19 TESTING

STUDENT NAME: _____ ID#: _____ Grade: _____

DATE OF BIRTH: _____ GENDER: M/F/Other

ETHNICITY: __Hispanic __Non-Hispanic __Islander __Other/Unknown

RACE: __Asian/Pacific __Native American/Indigenous __White __African American/Black

PARENT/GUARDIAN: _____

ADDRESS: _____

PHONE NUMBER: _____ EMAIL: _____

It is the top priority of Wilco Area Career Center ("Wilco") to uphold the health and safety of its school community. As such, to provide students with their clinical experience while proactively preventing the spread of Coronavirus (COVID-19), Wilco is offering on-site COVID-19 testing (Testing) for its students and employees. Some of our clinical sites have also offered to test students before they enter the facility. By signing this form, you are giving your permission for your child to participate in the testing process either at Wilco or at the clinical site. Please remember that clinical participation is required for state licensure.

Currently, Wilco is utilizing BinaxNOW, an antigen test that detects the presence of SARS-CoV-2, the virus that causes the COVID-19 infection. I understand and acknowledge that BinaxNOW was approved by the Food and Drug Administration (FDA) through Emergency Use Authorization (EUA) and therefore, may not have gone through the rigor of the full FDA approval process. While BinaxNOW is the current Testing source Wilco is utilizing, this on-site Testing may expand, and other Testing options may become available to Wilco. My signature below provides consent to Wilco to utilize BinaxNOW Testing, or any other Testing available to Wilco to detect whether the Student may be positive for COVID-19.

I understand that, as with any medical test, there is a potential for false positive or false negative results. I acknowledge that Testing may be administered in a manner that may produce inaccurate results and agree to seek additional medical attention as may be necessary to address the Student's health concerns. I acknowledge that negative test results may indicate that the demonstrated symptoms are not related to COVID-19. However, I also understand that if symptoms present or persist after the receipt of negative Testing results, it is best to reach out to a health care provider to determine the best course of action for the Student's care. In the case of positive results, Wilco will notify the Parent/Guardian, as well as the local health department as part of Wilco's obligation to participate in contact tracing. I acknowledge that despite its administration of the Testing, Wilco is not acting as the Student's medical provider. I acknowledge that this Testing does not replace the care of a medical provider. As the Parent/Guardian of the Student, I assume complete and full responsibility to take appropriate action with regards to the Testing results, including seeking medical advice, treatment and care. Furthermore, in response to the Testing results and the Student's current symptoms, I agree to keep the Student home from school as outlined in Wilco's mandatory Isolation/Quarantine Protocols.

As referenced above, I understand that as part of the Testing, Wilco is required to participate in contact tracing. I acknowledge that Testing may require Wilco to release information that may be protected under Health Insurance Portability Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), Illinois School Student Records Act (ISSRA) and/or other state, federal and local regulations pertaining to personal information. Such information may include but may not be limited to name, address, phone number, class schedules, bus routes, Testing results, etc. I hereby provide my consent to the

exchanging of this information as deemed necessary for the implementation and furtherance of the Testing, as well as contact tracing. I understand that protected health information will not be reused or disclosed by Wilco to any person or entity beyond what is outlined herein.

In consideration of being afforded the opportunity for the Student to participate in on-site testing at no cost, I individually and on behalf of Student release, waive, discharge, covenant not to sue and agree to hold harmless for any and all purposes Wilco, its board members, its agents, administrators, healthcare providers, volunteers, servants, and employees in their individual and official capacities from any and all liabilities, claims, demands, injuries or illnesses (including death), damages, legal costs including but not limited to court costs and attorney's fees and expenses that maybe sustained by myself or the Student while participating in the Testing, while traveling to and from the Testing, or while on Wilco property for the purpose of Testing.

By signing below, I attest that I have read, reviewed and understand the content of this document. I agree that I sign this document freely and voluntarily and am legally authorized to make decisions on behalf of the Student. I understand and agree that by signing this consent, I am authorizing Wilco or its clinical site to conduct Testing on the Student as deemed appropriate by relevant staff. I understand that I can revoke such consent at any time. Such revocation must be put in writing and directed to Elizabeth Kaufman, Wilco Director. I understand that my revocation of this authorization will not be effective for actions taken by Wilco in reliance upon my authorization below and prior to notice of my revocation.

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature (if over 18) Date

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____ - _____ - _____

States Where You Have Lived? _____

☐ Male ☐ Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____

(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

Race	A	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****

Student/Parent Handbook Acknowledgement and Pledge

Student Acknowledgement and Pledge

I acknowledge receiving and/or being provided electronic access to the Student/Parent Handbook and School Board policy on student behavior at www.wilco.k12.il.us. I have read these materials and understand all rules, responsibilities and expectations. In order to help keep my school safe, I pledge to adhere to all School and School District rules, policies and procedures.

I understand that the Student/Parent Handbook and School District policies may be amended during the year and that such changes are available on the School District website or in the school office.

I understand that my failure to return this acknowledgement and pledge will not relieve me from being responsible for knowing or complying with School and School District rules, policies and procedures.

_____ _____

Student Signature Date

Parent/Guardian Acknowledgement

I acknowledge receiving and/or being provided electronic access to the Student/Parent Handbook and School Board policy on student behavior at www.wilco.k12.il.us. I have read these materials and understand all rules, responsibilities and expectations.

I understand that the Student/Parent Handbook and School District policies may be amended during the year and that such changes are available on the School District website or in the school office.

I understand that my failure to return this acknowledgement will not relieve me or my child from being responsible for knowing or complying with School and School District rules, policies and procedures.

_____ _____

Parent/Guardian Signature Date

ELECTRONIC NETWORK ACCEPTABLE USE AGREEMENT

Student

I understand and will abide by the above Acceptable Use Agreement. I further understand that any violation of the regulations above is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken, and /or appropriate legal action may be instituted.

PRINT Student Name:_____

Student Signature:_____

WILCO Program:_____Session:_____

Date:_____

Parent or Guardian

As the parent or guardian of this student, I have read the Acceptable Use Agreement. I understand that this access is designed for educational purposes. I recognize it is impossible for WILCO to restrict assess to all controversial materials, and I will not hold WILCO (or any of its personnel) responsible for materials acquired on the network. Further, I accept responsibility for supervision if and when my child's use of downloaded material is not in a school setting. I hereby give my permission to allow Internet access for my child

PRINT Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Date:_____

Photo Release and Video Imaging

Unless notified in writing by the student's parent/guardian stating that they do not wish their child's picture to be used for public use, pictures taken of students may be placed in any Wilco publication, display or presentation. This includes but not limited to videos, computers, Wilco's website, or articles placed in the newspaper.

NO TRESPASS NOTICE

FOR ALL LAND, BUILDINGS AND VEHICLES OF

Wilco Area Career Center School

This **NOTICE** is to personally inform you that you are not permitted on **THE GROUNDS, IN ANY BUILDINGS, OR IN ANY VEHICLES** of Wilco Area Career Center School if you are in possession of any of the following:

Air Rifle or **Air Gun** **BB Gun** **Air Soft Gun** **Paintball Gun** **Pellet Gun** or any **Look-Alike Gun** of any kind that a reasonable person would believe to be a real gun regardless of the distance at which that person might see it.	**Knife** **Dagger** **Dirk** **Razor** **Stiletto,** or any other **Dangerous** or **Deadly Weapon** or **Instrument of Like** **Character.**

Anyone who disobeys this notice can be charged with **Criminal Trespass to State-Supported Land** and/or **Criminal Trespass to Vehicles.** Both of these offenses are Class A misdemeanors. You can be arrested. If you are convicted, you can be punished by up to one year in the Illinois Department of Corrections, Juvenile Division, and if you are 17 years of age or older, by up to 364 days in jail.

This serves as your written notice. This notice also is being read aloud to you on this date. This notice is also being sent to your parents or legal guardians.

Student Signature Date Name Printed

This notice prepared by the Will County State's Attorney

Student Emergency Contact

Wilco Area Career Center

500 Wilco Blvd. • Romeoville, IL 60446 • 815.838.6941 • Fax: 815.838.1163

PLEASE PRINT IN BLACK INK. ***All information is Required***

❑ Male
❑ Female
❑ Non-binary

Student's Name (Last) (First)

Student's Home Address

Student's Program Choice

City Zip Code

Primary Language spoken in the home?

Student lives with: ❑ Mother/Guardian ❑ Father/Guardian

Student's Home School

❑ Plainfield Central ❑ Plainfield South ❑ Plainfield North
❑ Bolingbrook ❑ Romeoville ❑ Plainfield East
❑ Reed-Custer ❑ Wilmington ❑Lemont
❑Lockport ❑Plfd. Academy ❑Phoenix

❑ Other: _____

Student Email

_____/_____/_____
Student Birth Date

(_____)_____
Home Phone

(_____)_____
Cell Phone

Mother / Guardian Information

Name

Address

City Zip

(_____)_____
Home Phone

Place of Employment

(_____)_____ (_____)_____
Business Phone Cell Phone

Email Address

Father / Guardian Information

Name

Address

City Zip

(_____)_____
Home Phone

Place of Employment

(_____)_____ (_____)_____
Business Phone Cell Phone

Email Address

Nondiscrimination Statement: It is the policy of the Wilco Area Career Center not to discriminate in its educational programs, activities, or employment policies with regard to race, color, sex, national origin, or handicap.

TO BE COMPLETED BY COUNSELOR FROM HOME SCHOOL (Please check all that apply.)

The State requires the following information for program funding purposes.

❑ Alaskan Native / American Indian
❑ Asian America / Pacific Islander
❑ Black – Non Hispanic
❑ Hispanic
❑ White – Non-Hispanic

❑ Academically Disadvantaged
❑ Economically Disadvantaged
❑ 504 Accommodation

❑ This student has an IEP

Year of Graduation:
❑ 2025
❑ 2026
❑ 2027
❑ _____

Session Preference
❑ Session I
❑ Session II
❑ Session III

Has Student had a career assessment? ❑ NO ❑ YES – *If yes, which one?* _____

Counselor's Name: _____ Counselor's Signature: _____

EMERGENCY INFORMATION (NOTE: Parents/Guardians are always first contact in case of illness or emergency.**)**

Please list two additional contacts in the event we are unable to contact the parent/guardian.

1st Emergency Contact Name: _____ Daytime Phone: (_____)_____

2nd Emergency Contact Name: _____ Daytime Phone: (_____)_____

Is your student allergic to any medication? ❑ NO ❑YES If yes, which ones? _____
Does your student wear contact lenses? ❑ NO ❑YES
Does your student have any physical disabilities? ❑ NO ❑YES If yes, please list them: _____

Doctor's Name: _____ Phone Number: (_____)_____

I authorize Wilco Area Career Center to take action in case of emergency – Parent/Guardian's Signature: _____

Revised 7/18/2023