

Virginia Appalachian Tricollege Nursing Program

Pregnancy Statement

Form C

Section A: (To be completed by the student)

Student Name:	
EMPL ID:	Expected Date of Delivery:
Physician Name:	
Physician Location/Phone Number#:	
Name and phone number of individual(s) to be contacted in case of emergency:	
Student Statement: As a student of the VATNP, I am aware of the potential exposure to infectious/contagious diseases, toxic substances and the danger to pregnant students and their unborn fetus, which may occur during clinical experiences. I am also aware of the physical demands of the program as stated in the college catalog.	
Student Signature:	Date:

Section B: (To be completed by the health care provider)

Please use the following information to determine if this student can participate in clinical experiences. In some situations, the policies of clinical agencies to which the student is assigned may supersede your recommendations.	
<ul style="list-style-type: none"> • Each clinical day is 8-12 hours in length • There is potential exposure to infectious/contagious diseases, and toxic substances • Students are expected to complete nursing care activities comparable to that of a staff nurse with the supervision of their clinical instructor • Physical demands in the nursing program include duties that frequently require squatting, bending, kneeling, reaching, and stair climbing, lifting and carrying up to 50 pounds; frequent pushing and pulling up to 200 pounds with assistance; occasional lifting up to 200 pounds with assistance and occasional carrying up to 51-74 pounds. Duties also require constant use of sense of sight, hearing, touch, and speech. Environmental conditions include procedures that involve handling blood and body fluids using standard (universal) precautions 	
Please indicate your recommendation regarding this student's ability to participate in clinical experiences.	
_____ may participate in clinical activities	
_____ has no limitations	
_____ has physical and/or mental impairments: please specify limitations	
_____ may NOT participate in clinical activities at this time, may reconsider after: _____ (date)	
Healthcare Provider Signature/Title:	Date: