

## STUDENT HANDBOOK DECLARATION FORM

To be completed by all NHS Students

*All students accepted to a Nursing & Health Sciences (NHS) Program must print a copy of this form and upload a signed copy to their CastleBranch account.*

### Accountability Statement

I \_\_\_\_\_ hereby declare that I am responsible and  
Print Full Name  
accountable for the information set forth in the 2025-2026 NHS Student Handbook, including the program-specific content in the appropriate Appendix. I understand this handbook is subject to change. I also understand that I will be informed via my LC State email account or a posting to the division web page ([www.lcsc.edu/nursing](http://www.lcsc.edu/nursing)) of any policy changes made during this academic year. My signature below indicates my agreement to familiarize myself with the contents of this Handbook and abide by these NHS policies to the best of my ability. I understand I am to refer to the [LC State Student Handbook](#) for institution-related policies and procedures. I understand I am to use WarriorMail for all electronic communication with faculty and that I am responsible for accessing WarriorMail and the NHS Division website on a regular basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Program

\_\_\_\_\_  
Date

### Confidentiality Statement

I \_\_\_\_\_ hereby declare that I have read the confidentiality statement in this handbook. I have been provided the opportunity to ask questions and understand what constitutes confidential information. I agree, as a student of Lewis-Clark State, to keep confidential information to which I am exposed during all clinical and classroom experiences. This includes information presented in clinical mid or post conference, case studies, and classroom discussions, as well as information associated with patients to whom I provide care. I understand that if I am found to have shared confidential information with unauthorized individuals in any form (verbal, written, electronic, or through any social medium), it may be grounds for immediate termination from the NHS program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Program

\_\_\_\_\_  
Date

## **Student Photo/ Video Consent**

I consent for the NHS Division at Lewis-Clark State to place my photo in my NHS student file. The photo will be a replica of the one taken for my LC State NHS Student ID badge. I understand the purpose is to help faculty and staff become acquainted with NHS Students and to aid in identifying NHS Students should an emergency arise. I give Lewis-Clark State permission to copyright and publish all or any part of photographs, video, voice recordings, and/ or written/ spoken statements taken of me for use in any public relations and/ or marketing campaigns or collateral for Lewis-Clark State. I understand that I will receive no compensation for the use of my likeness.

In addition, if I have supplied my testimonial, it has been done by my own free will, involving no type of incentive or coercion. I understand that my testimonial may be used in connection with promoting Lewis-Clark State. I authorize Lewis-Clark State to use my name, brief biographical information, and the testimonial as defined on this form. Additionally, I waive any right to inspect or approve the finished product, including written copy, wherein my likeness or my testimonial appears.

I am 18 years of age or older, and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing before signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature \_\_\_\_\_ Program \_\_\_\_\_ Date \_\_\_\_\_

**Student Code Violations Consent Disclosure**

I hereby authorize the Vice President for Student Affairs to release any records of LC State Student Code violations that have occurred while I have been enrolled. I understand that these records will be reviewed as part of a formal background check related to admission to my program of study.

Signature \_\_\_\_\_ Program \_\_\_\_\_ Date \_\_\_\_\_

**Authorization for Release of Record**

I hereby authorize the NHS Division to release information as requested by clinical agencies. Such information may include, but is not limited to maintenance of health requirements and background check results.

Signature \_\_\_\_\_ Program \_\_\_\_\_ Date \_\_\_\_\_

**Drug Testing Consent**

I \_\_\_\_\_ have read the LC State NHS Drug and Alcohol Testing Policy. I understand and agree to comply with the policies and procedures and specifically consent to Drug and Alcohol Testing as provided for in the Drug and Alcohol Testing Policy. I understand some clinical agencies may require students to have an additional drug screen or other testing performed prior to allowing students to complete their clinical in their agencies. I further understand I am responsible for the cost of such testing.

Signature \_\_\_\_\_ Program \_\_\_\_\_ Date \_\_\_\_\_