# Nursing and Allied Health Department
# Student Health Requirements (Nursing Assistant Program)

**This form is to be reviewed by the Physician filling out the physical examination forms**

**to enter the Nurse Assistant Program at Clovis Adult Education, students must be able to meet the following requirements:**

## Mental/Emotional

Students must have sufficient emotional stability to perform under stress produced by academic study and the necessity of performing patient care in real patient care situations while being observed by instructors and agency personnel.

## Strength and Stamina

Students must be able to:

- Work at various clinical sites up to 8-12 hours per day.
- Attend theory classes up to 8 hours per day.
- Lift /transfer patients of various sizes and weights on to & off examination tables.
- Push, pull, lift, turn as in patient positioning, and manipulating equipment.
- Lift floor to waist.
- Walk up to 500 feet.
- Sit for prolonged periods.
- Stand for prolonged periods.

## Flexibility

Students must be able to:

- Reach above shoulder height
- Bend over
- Crouch to stoop
- Twist/Pivot

## Fine manipulation

Students must be able to:

- Manipulate ampules, syringes, and medication containers.
- Write legibly and enter data into computers using touch screens and keyboards.

## Sensory abilities

Students must be able to:

- See well enough to read syringe graduations and medication labels.
- Hear well enough to receive information accurately over the telephone and to discriminate sounds heard through a stethoscope.
- Use all physical senses (hearing, seeing, feeling, and smelling) in a manner that allows the student to accurately assess the patient and clinical situation.

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# Health Forms and Immunization Requirements for Nursing and Allied Health Programs (Nursing Assistant Program)

## Please review the chart below for all health requirements

<table>
<tr><th>Forms, Vaccinations & Titers</th><th>Nurse Assistant</th></tr>
<tr><td>CAE Student Questionnaire</td><td>✓</td></tr>
<tr><td>CAE Physical Examination Form</td><td>✓</td></tr>
<tr><td>CAE Immunization Form</td><td>✓</td></tr>
<tr><td>COVID 19 Vaccine and Booster</td><td>✓</td></tr>
<tr><td>Influenza (Flu) current season</td><td>✓</td></tr>
<tr><td>You must compete 1 of the 3 listed below<br>QuantiFERON TB Gold+ (Blood Test)<br>Negative 2-Step TB Test no older than 3 months prior to the start date.<br>Positive TB must provide an X-ray</td><td>✓</td></tr>
<tr><td>Hepatitis B Surface Antibody (AB)<br>Positive TITER, if negative then series of 3 shots will be needed.<br>What is a titer?<br>A titer is a laboratory test that measures the presence and number of antibodies in blood. A titer may be used to prove immunity to a disease. A blood sample is taken and tested. If the test is positive (above a particular known value) the individual has immunity.</td><td>✓</td></tr>
<tr><td>Heplisav-B 2-dose HepB vaccine series only applies when both doses consist of HepB-CpG, administered at least 4 weeks apart.<br>Series consisting of combination of 1 dose of HepB-CpG and vaccine from a different manufacturer (HepB-alum) should be do the following:<ul><li>Adhere to the 3-dose schedule minimum intervals of 4 weeks between dose 1 and 2, 8 weeks between dose 2 and 3, and 16 weeks between dose 1 and 3. However, if HepB-CpG is substituted for dose 2 of HepB-alum, a provider has the option of administering the next does of HepB-CpG a minimum of 4 weeks form the previous dose for complete series.</li></ul></td><td>✓</td></tr>
</table>

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# Nursing and Allied Health Department
## Physical Examination Form (Nursing Assistant Program)

NAME: ______________________________________________________________ Date of Birth_____/_____/______

HEIGHT: ________ft _________in WEIGHT: ___________lbs. TEMP: ___________________

RESP: _________________________________________________________ B/P_____________________

HEENT: _________________________________________________________________________________________________

CARDIOVASCULAR: __________________________________________________________________________________

GI: _____________________________________________________________________________________________________

EXTREMETIES: ____________________________________________________________________________________

NEUROLOGICAL: Able to perform fine motor skills? Yes______ No_______

MUSCULO/SKELETAL: Able to assist in lifting patients of varying weights and sizes? Yes______ No_______

Able to squat with forward reach Yes______ No_______

Able to lift from floor to waist Yes______ No_______

Able to lift from chair, pivot and place on chair behind you Yes______ No_______

Grip: Right________________ Left ________________

**IMPORTANT:** The Physician **MUST** answer the following questions:

**This person is free of communicable disease and does not have any health condition(s) that would create a hazard to oneself, fellow students, residents, patients, or visitors.**

YES_______ NO_______ **If no, please explain**___________________________________________________________

_____________________________________________________________________________________________________

**Attached is a list of "Health Requirements" Does this person have the ability to meet these health requirements?**

YES_______ NO________

**If no, please explain**____________________________________________________________________________________

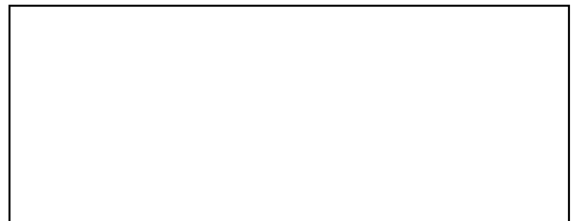
_____________________________________________________________________________________________________

**Dr. Signature:** _________________________________________________ **Date:** _______________________

**Address:** ______________________________________________________ **Phone:** _______________________

__________________________________________________________________

****Please attach doctor's office business card to this form and/or doctor's office stamp here.**



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# Nursing and Allied Health Department
# Immunization Requirements (Nursing Assistant Program)

Name______________________________________________________ Date of Birth____/____/____

**IMPORTANT:** *Documentation such as a printout, **MUST** be provided along with this form.*

**PPD step 1 (TB)** Date given __________ Date read __________ Result _____________ Given by ______________

**PPD step 2 (TB)** Date given __________ Date read __________ Result _____________ Given by ______________

**Chest X-ray (if positive PPD)** Date given __________

**QuantiFERON TB Gold+ (Blood Test)** Date given ____________ Results __________ Given by _____________

**Covid 19** Manufacturer________________ Dose 1 given ________________ Dose 2 given________________

**Covid Booster** Date given ________________

**Influenza (Flu) Vaccine** Date given ______________

**Hepatitis B** Positive titer date _______________ if negative, receive 3 follow up doses.

**Hepatitis-B #1** _______________ **Hepatitis #2**________________ **Hepatitis #3**______________

**Heplisav-B #1** _______________ **Heplisav-B #2**______________

**Additional Notes:**

**Dr. Signature:** ___________________________________________ **Date:** ____________________________

**Address:** ________________________________________________ **Phone:** ___________________________

__________________________________________________________

**** Please attach doctor's office business card to this form and/or doctor's office stamp here.**

# Nursing and Allied Health Department
# Student Health Questionnaire (Nursing Assistant Program)

Name: ____________________________________________ DOB: _____/______/______ Sex: M / F

Address____________________________________ Apt #________ City_______________ Zip _________

Phone: (_____) ____________________________ Alternate # (_____) ___________________________________

Family Physician: ________________________________________ Phone: ___________________________

Under current medical care? Yes/No If yes, please explain: ________________________________________

Family History: Nervous or Mental Illness? Yes/No Diabetes? Yes/No Tuberculosis? Yes/ No

**Have you had or do you have any problems with the following:** ***(Please answer to the best of your knowledge)***

| DISEASE OF: | YES | NO | DISEASE OF: | YES | NO | DISEASE OF: | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Brain | | | Genitals | | | Bronchitis | | |
| Rheumatic Fever | | | Eyes | | | Lymph | | |
| Paralysis | | | Ears | | | Chronic constipation | | |
| Frequent or painful urination | | | Nose | | | Black or bloody bowel movements | | |
| Frequent sore throat | | | Cancers/Tumors | | | Frequent headaches | | |
| Hay Fever | | | Heart | | | Asthma | | |
| Swollen ankles | | | Lungs | | | Blood in urine | | |
| Fainting Spells | | | Diabetes | | | Stomach | | |
| Intestine | | | Arthritis | | | High blood pressure | | |
| Hernia (rupture) | | | Chest pains | | | Jaundice | | |
| Chronic cough | | | Liver | | | Shortness of breath | | |
| Coughing up blood | | | Spleen | | | Nervous breakdown | | |
| Backaches | | | Ulcers | | | Painful flat feet | | |
| Kidney stones | | | Gallbladder | | | Pneumonia | | |
| Bone | | | Kidneys | | | Chronic sinus infections | | |
| Chronic indigestion | | | Bladder | | | Allergies | | |
| Tuberculosis | | | Injuries | | | Operations | | |
| Vomiting of blood | | | Piles | | | Convulsions or seizures | | |
| Abnormal menstrual periods | | | Joints | | | Recurrent nausea | | |
| Bleeding disorder | | | Back (spine) | | | Recurrent vomiting | | |

***Please give details of information to all "yes" answers on the reverse of this page***

Any other serious illnesses (please explain) ______________________________________________________

- Do you hear well? Yes No If NO, explain__________________________________________
- Do you see well? Yes No If NO, explain__________________________________________
- Have you ever been rejected or discharged from the military service because of illness or injury? Yes /No
  If YES, explain______________________________________________________________________
- Do you have any medical conditions, which may interfere with your work? Yes No
  If YES, please state details of conditions ___________________________________________________

**I, the individual signing below, hereby affirm that the responses provided above are truthful, and grant the examining Medical Professional authorization to submit a report to the Clovis Adult Education Nursing and Allied Health Department.**

**Student Signature:** ____________________________________________ **Date:** _____________________