CLOVIS ADULT EDUCATION
Improving Lives through Education

Nursing and Allied Health Department
Student Health Requirements

This form is to be reviewed by the Physician filling out the Physical Examination Form.

To enter into and complete any **Nursing and Allied Health Program** at Clovis Adult, 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 for 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.

Pregnancy

Students must be able to:

- Provide a release from their OB doctor to be in the clinical setting with no restrictions.
- Have a ***monthly*** documented release that the student may *continue* in clinical with no restrictions

In addition to the above-mentioned requirements, students must have adequate management of chronic illnesses so that neither patients nor the student is at risk of harm.

Students must complete all required immunizations and the health screening to participate in any of the Nursing and Allied Health Programs.

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Health Forms and Immunization Requirements for Nursing and Allied Health Programs

Please review the following chart to see the forms and immunizations that will be required to enter your desired program.

Forms & Vaccinations	Nurse Assistant	Home Health Aide	Vocational Nurse
CAE Student Questionnaire	✓	✓	✓
CAE Physical Examination Form	✓	✓	✓
CAE Immunization Form	✓	✓	✓
COVID 19 (Can attend clinical 2 weeks after final dose with either Moderna, Pfizer, or Johnson & Johnson)	✓	✓	✓
COVID 19 BOOSTER	✓	✓	✓
Immunization Card *(yellow card or printout)*	✓	✓	✓
Negative TB Test *no older than 3 months prior to the start date*	✓	✓	✓
Tdap (Pertussis)			✓
Rubella			✓
Rubeola			✓
Varicella			✓
Hepatitis B (series of 3)	✓	✓	
Hepatitis B Surface Antibody (AB) Positive TITER ONLY	**Please see "NOTE" for Vocational Nurse**		✓
Influenza (Flu) in season	✓	✓	✓
NOTICE: If your immunizations are over 10 years old, you must get a titer			

NOTES:

Vocational Nurse (VN)

- ONLY a **Positive Hepatitis B Surface Antibody AB TITER** will be accepted to enter the Vocational Nurse Program. The Hep B series of 3 vaccine is not accepted.

What is a titer?

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.

NURSING and ALLIED HEALTH DEPARTMENT
Student Health Questionnaire

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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 undersigned, certify the above answers are true, and give the examining Physician permission to submit a report to the Clovis Adult Education Nursing and Allied Health Department.

Student Signature: _____ **Date:** _____

NURSING and ALLIED HEALTH DEPARTMENT

Physical Examination Form

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 _____

2-point pinch: 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 himself, 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.**

RETURN THIS FORM TO Clovis Adult Education

NURSING and ALLIED HEALTH DEPARTMENT
Immunization Requirements

CLOVIS ADULT EDUCATION
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Program _____

Name_____ Date of Birth____/____/____

IMPORTANT: *Documentation such as a printout or a written prescription stating that the following has been completed **MUST** be attached to this form.*

PPD (TB) Date given _____ Date read _____ Result _____ given by _____

PPD (TB) Date given _____ Date read _____ Result _____ given by _____

Chest X-ray Date given _____

Covid 19 Manufacturer_____ Dose 1 given _____ Dose 2 given_____

Covid Booster Date given _____

Influenza (Flu) Vaccine Date given _____

Tdap (Pertussis) Vaccine Date given _____

Rubella Positive titer date _____ or 2 immunizations #1 date _____ #2 date_____

Rubeola Positive titer date _____ or 2 immunizations #1 date _____ #2 date_____

Mumps Positive titer date _____ or 2 immunizations #1 date _____ #2 date_____

Varicella Positive titer date _____ or 2 immunizations #1 date _____ #2 date_____

Hepatitis B Positive titer date _____ **(required for Vocational Nurse)**

or series of 3 immunizations

Hepatitis #1 _____ **Hepatitis #2**_____ **Hepatitis #3**_____

Additional Notes:

Dr. Signature: _____ **Date:** _____

Address: _____ **Phone:** _____

_____

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

RETURN THIS FORM TO Clovis Adult Education