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 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.

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	Home Health Aide	Nurse Assistant	Clinical Medical Assistant	Vocational Nurse
CAE Student Questionnaire	✓	✓	✓	✓
CAE Physical Examination Form	✓	✓	✓	✓
CAE Immunization Form	✓	✓	✓	✓
Immunization Card *(yellow card or printout)*	✓	✓	✓	✓
***QuantiFERON Gold Test**	**Please see "NOTE" for Vocational Nurse**			✓
Negative TB Test *no older than 3 months prior to the start date*	✓	✓	✓	✓
Tdap (Pertussis)			✓	✓
Rubella			✓	✓
Rubeola			✓	✓
Varicella			✓	✓
Hepatitis B (series of 3)	✓	✓	✓	✓
Influenza (Flu) in season	✓	✓	✓	✓

NOTE:

<u>Vocational Nurse (VN)</u>

- A **Negative 2-step TB Test** is required to ***enter*** into the Vocational Nurse Program
- A **Negative QuantiFERON Gold Test (QFT-G)** is required ***during*** the program, 1 month prior to attending the Reedley Clinical Facility. *(more information will be given about this requirement at the Mandatory Orientation.)*

NURSING and ALLIED HEALTH DEPARTMENT
Student Health Questionnaire

Program: Choose an item.

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:** ____________________

RETURN THIS FORM TO CAE

NURSING and ALLIED HEALTH DEPARTMENT

Physical Examination Form

Program: Choose an item.

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 ______________________________

____

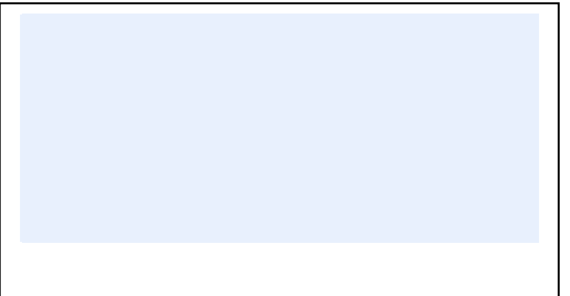
Attached is a list of "Health Requirements" Does this person have the ability to meet these health requirements? YES ☐ NO ☐ If no, please explain ______________________________

____

Dr. Signature: ______________________________ **Date:** ________________

Address: ______________________________ **Phone:** ________________

City: ________________ **ST.:** _____ **ZIP:** _________



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

RETURN THIS FORM TO CAE

NURSING and ALLIED HEALTH DEPARTMENT

Immunization Requirements

Program Choose an item.

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.*

QuantiFERON Gold Test *(VN only)* Date given ________ Result __________

PPD (TB) Date given ________ Date read ________ Result __________ given by ______

PPD (TB) Date given ________ Date read ________ Result __________ given by ______

Chest X-ray 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 ___________ **or** series of 3 immunizations

Hepatitis #1 ____________ **Hepatitis #2** ____________ **Hepatitis #3** ____________

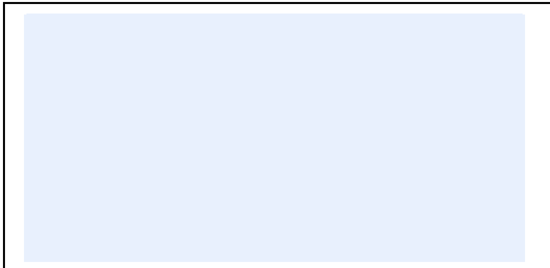
Additional Notes: ____

Dr. Signature: ______________________________ **Date:** ____________

Address: ______________________________ **Phone:** ____________

City: ______________________ **ST.:** ____ **ZIP:** ________

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



RETURN THIS FORM TO CAE