OWENS COMMUNITY COLLEGE
School of Nursing & Health Professions
NURSE ASSISTANT TRAINING PROGRAM
PRE-ATTENDANCE HEALTH REQUIREMENTS

Name ____ **Date of Birth**________________________________

Physician Name & Address ____

Tuberculosis
2 Step first year, then 1 step yearly NOTE: Tine test is NOT accepted.

STEP 1	**STEP 2**
PPD 0.1 ml ID	PPD 0.1 ml ID
READ in 48 – 72 Hours	READ in 48 – 72 Hours
Date Administered _______________________________	**Date Administered** _________________________________
Signature ______________________________________	**Signature** ____
Date Read ______________________________________	**Date Read** ____
Results ____	**Results** ____
Signature_______________________________________	**Signature**____

Any student who has a positive Mantoux must have a Chest x-ray and be given medical clearance before beginning class.
CXR Date ____________________ Attach copy of interpretation.
Absence of Active Disease **Yes**________
* **No.** Please Explain: ____

____

PHYSICAL EXAMINATION

Height _________________________________ Weight ____
Temperature _____________________________ Pulse ____
Respiration ______________________________ Blood Pressure ________________________________

General Appearance	WNL	Except: ____
Skin	WNL	Except: ____
HEENT	WNL	Except: ____
Eyes	WNL	Except: ____
Hearing	WNL	Except: ____
Respiratory	WNL	Except: ____
Cardiovascular	WNL	Except: ____
Neurological	WNL	Except: ____
Musculo-Skeletal	WNL	Except: ____
Lifting Ability	WNL	Except: ____
Abdomen	WNL	Except: ____

Is this individual fit for duty and free of communicable disease? ____ ***Yes*** ____ ***No ****

* If no, please explain. ____

____

Does this individual have any condition(s) that might subject them to an emergency in the classroom, laboratory or clinical setting?

____***Yes**** ____***No***

* If yes, please explain. ____

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After this examination, do you believe that this person's health history, physical and mental health findings justify his/her undertaking the Nurse Aide Training Program, including clinical experience with direct patient contact in health care agencies?
____ ***Yes*** ____ ***No ****

*If no, please explain.____

Signature: (MD, DO or NP) ____Date: __________