Health Examination Form for Admission to Nurse Aide Training Program

To Be Completed and Reviewed by Student *(please print)*

Name: _____ **Date of Birth:** _____
Street Address: _____
City/State/Zip: _____
Phone Number: _____

Influenza Vaccine:

Documentation of a current influenza vaccine is required when participating in a Nurse Aide Training Program during the months of October through March (flu season). Please provide documentation of vaccine along with your required admission paperwork to the HACC Nurse Aide Office. **Date influenza vaccine administered:** _____

To Be Completed at Physician's Office/Medical Clinic *(please print)*

Two-step Tuberculin test, PPD, or Mantoux type *(This is required. Form is not complete without read and reported results.)*

Step 1 Date Administered: _____ R. arm/L. arm *(circle one)*
By whom- signature/title: _____
Date Read: _____ *(Must be read 48-72 hrs. after administered)*
By whom- signature/title : _____
Results: _____ mm (results must be measured in millimeters) **Positive results are equal to or greater than 10mm.**

Step 2 must be administered 7-21 days after the first PPD is read

Step 2 Date Administered: _____ R. arm/L. arm *(circle one)*
By whom- signature/title: _____
Date Read: _____ *(Must be read 48 -72 hrs. after administered)*
By whom- signature/title: _____
Results: _____ mm (results must be measured in millimeters) **Positive results are equal to or greater than 10mm.**

If PPD results are positive, please describe the treatment given and the date completed: _____

If IGRA blood test is given instead of PPD's, please indicate date completed and results: _____
Acceptable IGRA blood tests include QuantiFERON – TB Gold in-Tube test (QFT-GIT) or SPOT TB test (T-Spot).
Please provide documentation of IGRA blood test results along with this form.

To Be Completed by MD, DO, CRNP, or PA: *(please complete all sections, including signature, title, and contact information)*

Yes **No** I certify that the student/employee is free from communicable diseases in the communicable state.
Yes **No** I certify that the student/employee has no medical conditions/restrictions, which will prevent them from performing the essential function of the job.
Yes **No** I certify that the student/employee is able to lift 40 pounds to waist level without restrictions.

Comments: If the applicant has any limitations, please explain. _____

Date of Examination: _____ Phone Number: _____
Examiner's Name and Title: _____
Examiner's Signature: _____
Street Address: _____
City/State/Zip: _____

Please direct any questions to: HACC Nurse Aide Training | (717) 221-1352 | nurseaide@hacc.edu