



HEALTH RECORD

NURSING ASSISTANT TECHNICAL ABILITY STANDARDS

Students matriculating in and graduating from Parkland College's Nursing Assistant program must be able to meet the technical requirements of the academic program and must not pose a threat to the well-being of patients, other students, staff, or themselves.

As an incoming nursing assistant student, you must be able to carry out the following skills and abilities:

1. Sufficient motor function to elicit information from clients by palpation, auscultation, percussion, and other assessment maneuvers.
2. The ability to execute motor movements reasonably required to provide direct nursing care and emergency treatment to clients, e.g. transferring, lifting, and turning clients; providing hygienic care; assisting clients in activities of daily living; and providing cardiopulmonary resuscitation.
3. The ability to observe a client accurately at a distance and close at hand. This requires functional use of the senses of vision and hearing.
4. The ability to closely examine images or other forms of output created by diagnostic equipment.
5. Adequate skin integrity, without the presence of open, weeping lesions.
6. Full range of motion of body joints, fine motor movements of the hands, and the ability to stoop and bend.
7. The ability to lift up to 50 pounds of weight on a daily basis.
8. The ability to carry objects weighing up to 50 pounds on a daily basis.
9. The ability to push or pull an occupied wheelchair, cart, or gurney on a daily basis.
10. The ability to use the English language to communicate effectively in a rational, coherent manner, both orally and in writing, with individuals of all professions and social levels.
11. The ability to maintain composure when subjected to high stress levels.
12. The ability to adapt effectively to changing environments, especially those with high tension levels.
13. The ability to respond in an emotionally controlled manner in learning situations and emergencies.
14. The students will have the ability to access transportation in order to get to clinical assignments in a timely manner.

If you have concerns that you do not meet these standards, please call the Wellness Coordinator at 217/373-3879 to discuss this matter.

FOR OFFICE USE ONLY

Incomplete <input type="checkbox"/> Date deficiency letter sent:	Complete <input type="checkbox"/> Reviewed by: Date:	Entered <input type="checkbox"/> Entered by:
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I give my consent for this health record (Parts I, II, and III) to be reviewed by the program director and released to clinical agencies for compliance audits.

Student's Signature _____

Date _____

PART I: *To be completed by the student (please print).*

CHECK YOUR PROGRAM:

- CMA CNA DHG DTP EMT LPN MSG
 NUR OTA RTT SUR VTT XRA

Name (print — last, first, middle)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Local street address		
City	Zip code	Telephone
ID number		Birth date

MEDICAL HISTORY

Please check which of the following problems you now have or have had, and if possible, indicate the year.

- Tuberculosis _____
- Diabetes _____
- High blood pressure _____
- Cancer _____
- Ulcer _____
- Lung disease _____
- Kidney disease _____
- Blood disorder _____
- Seizure _____
- Skin allergies _____
- Asthma _____
- Heart disease _____
- Back trouble _____
- Shortness of breath _____
- Fainting or dizzy spells _____
- Head or spinal injuries _____
- Liver disease _____
- Headaches _____
- Measles _____
- Mumps _____
- Rubella (German measles) _____
- Chicken pox _____
- Other (specify) _____

PART II: *To be completed and signed by a health care provider. All dates must include month, day, year.*

MEASLES (RUBEOLA) — required for all programs

Persons born prior to 1957 are considered to be immune to measles.

1. Immunization with live virus vaccine:

Date 1 _____ Date 2 _____

(two doses given at least 30 days apart; both doses given on or after January 1, 1968, and given on or after first birthday)

or

2. Immunity confirmed by blood titer:

Date of test _____ Result _____

(attach copy of laboratory report)

MUMPS — required for all programs

Persons born prior to 1957 are considered to be immune to mumps.

1. Immunization with live virus vaccine:

Date 1 _____ Date 2 _____

(given in 1969 or later and given on or after first birthday)

or

2. Immunity confirmed by blood titer:

Date of test _____ Result _____

(attach copy of laboratory report)

RUBELLA (GERMAN MEASLES) — required for all programs

1. Immunization with live virus vaccine:

Date 1 _____ Date 2 _____

(given in June 1969 or later and on or after first birthday)

or

2. Immunity confirmed by blood titer:

Date of test _____ Result _____

(attach copy of laboratory report)

TETANUS AND DIPHTHERIA — required for EMT and VTT

Date of most recent booster _____

Name (print) _____
ID number _____

VARICELLA (CHICKEN POX) — immunity required for CMA, DTP, LPN, NUR, OTA, RTT, SUR, and XRA programs only

1. Varicella immunizations

Date 1 _____ Date 2 _____

or

2. Immunity confirmed by blood titer:

Date of test _____ Result _____

(attach copy of laboratory report)

HEPATITIS A VACCINE — required for DTP

Date 1 _____ Date 2 _____

HEPATITIS B VACCINE — required for all programs except VTT. Postvaccination testing for serologic response (titer) is highly recommended.

Dose #1 Date _____

Dose #2 Date _____

Dose #3 Date _____

Immunity confirmed by blood titer:

Date of test _____ Result _____

(attach copy of laboratory report)

RABIES VACCINATION — required for VTT

Dose #1 Date _____

Dose #2 Date _____

Dose #3 Date _____

TUBERCULOSIS SCREENING — initial 2-step TB test (must be Mantoux; TB tine tests are not acceptable) required for all programs except VTT.

Tests must be performed within 9 months prior to the student starting the program. After initial testing, a yearly single-step Mantoux test is required for all programs except VTT. If the student has a positive TB test, a chest x-ray must be performed and a copy of the report attached to this record.

1. Has student ever had a positive TB skin test?

No (go to #2) Yes (year) _____

If yes, medication was not prescribed

If yes, medication was prescribed

Medication name _____

How long taken _____

2. Has student ever had BCG vaccine?

No Yes (year) _____

(persons who have received BCG vaccine are required to have a TB skin test unless they have had a previous positive reaction)

3. 2-step TB test: two Mantoux TB tests given one to three weeks apart

#1 Date given _____ Date read _____ Result _____

#2 Date given _____ Date read _____ Result _____

4. Chest x-ray, if necessary *(attach copy of report)*:

Date _____ Result _____

5. Annual one-step TB testing (Parkland use only):

Date given _____ Date read _____ Result _____

Date given _____ Date read _____ Result _____

Date given _____ Date read _____ Result _____

Date given _____ Date read _____ Result _____

BASIC CPR — required for MSG

HEALTHCARE PROVIDER CPR — required for CMA, DHG, DTP, EMT, LPN, NUR, OTA, RTT, SUR, and XRA programs

Renewal date _____ Renewal date _____

(attach copy of CPR card)

HEALTHCARE PROVIDER VERIFYING INFORMATION FOR PART II.

Name (print) _____

Signature _____

Address _____

Telephone _____

Date _____

PART III — Physical Exam

To be completed by physician or nurse practitioner performing exam.

Name (print)			
Height		Weight	
BP (L)	BP (R)	Pulse	
Hearing acuity	Corrected vision (Snellen)		
	R 20/	L 20/	

ABNORMALITIES

YES NO

1. Head, ears, nose, or throat.....
2. Respiratory.....
3. Cardiovascular.....
 - Organic heart murmur.....
4. Gastrointestinal.....
5. Hernia.....
6. Eyes.....
7. Genitourinary.....
 - Severe menstrual cramps.....
8. Musculoskeletal.....
9. Metabolic/endocrine.....
10. Neuropsychiatric.....
11. Neurological.....
12. Skin.....

RECOMMENDATIONS FOR PHYSICAL ACTIVITY:

History of back injury or back problems? Yes No

If yes, please describe _____

Able to regularly lift 25% of body weight? Yes No

ABNORMALITIES/RECOMMENDED TREATMENT:

DESCRIPTION OF STUDENT'S CHRONIC ILLNESSES OR CONDITIONS, IF ANY:

MEDICATION/DRUG USE:

1. Prescribed _____
 2. Over-the-counter _____
 3. Alcohol _____
- Tobacco _____
- Recreational Drugs _____

Based upon my exam and knowledge of this patient, I believe s/he can perform the technical skills (as outlined on the front of this record) required to be successful in this program.

YES NO

If no, please explain _____

Physician's name (print) _____ Date _____

Physician's signature _____ Telephone _____

Address _____

RETURN COMPLETED FORM TO:

Wellness Coordinator, Parkland College, Room L234, 2400 West Bradley Avenue, Champaign Illinois 61821-1899