CATTARAUGUS-ALLEGANY BOCES
NURSE AIDE/HOME HEALTH AIDE PROGRAM
1825 WINDFALL ROAD
OLEAN, NEW YORK 14760

PRE-ENTRANCE MEDICAL EXAMINATION

NAME OF STUDENT _____
(Last) (First) (Middle)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH: _____

MEDICAL HISTORY (to be completed by student):

Medical History of Family. *(Please include heart or kidney disease, cancer, hypertension, diabetes, mental or nervous disorders, and other chronic illness).*

_____

_____

Medical History of Applicant.

1. Describe any hospitalizations _____

_____

2. Childhood diseases _____

3. Other diseases (Cancer, Heart Disease, Kidneys) _____

4. Injuries, broken bones, back problems _____

5. Operations _____

6. Epilepsy _____

7. Eye, Ear problems _____

8. Hoarseness, cough, or shortness of breath on moderate exertion _____

9. History of jaundice _____

10. Any allergies, including drug reactions? _____

11. Are you currently receiving any therapy or medication? Yes ☐ No ☐

If YES, please specify _____

DATE: _____ STUDENT SIGNATURE: _____

THIS SIDE TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

_____ Height _____ Weight

Eyes _____ Glasses □ Yes □ No

Ears _____ Nose _____ Sinuses _____

Throat _____ Adenoids _____ Tonsils _____

Chest _____ Lungs _____

Heart _____

Pulse Rate & Rhythm _____ Blood pressure _____

Breasts _____

Abdomen _____ Scars _____

Tenderness _____ Palpable Masses _____

Back _____ Posture _____

Genitalia _____

Menstrual History _____

Extremities _____

EXAMINER: PLEASE COMPLETE AND SIGN BELOW:

Lifting and transferring patients is frequently required of Practical Nursing/Nurse Aide students. In my opinion, this person □ is □ is not physically fit to perform these duties.

Does this person have any limitations that would interfere with their ability to function as a Practical Nurse or Nurse Aide? □ Yes □ No

Recommendations: _____

Date _____ Physician's Signature _____

Address _____

Please be advised that employment in the health care field may require a police background check and/or drug testing.

I, _____, do not abuse drugs or alcohol.
(Student)

CATTARAUGUS-ALLEGANY BOCES
NURSE AIDE/HOME HEALTH AIDE PROGRAM
IMMUNIZATION RECORD

NAME _____

All students must be in compliance with the New York State Department of Health Immunization Law as related to health care workers. We must have documentation of the immunizations listed below:

MEASLES, MUMPS, RUBELLA - Anyone born after January 1, 1957 must show documentation of **TWO** vaccinations for measles, **ONE** for mumps and **ONE** for rubella. You may be able to provide blood test results (titers) that demonstrate immunity to any of these diseases. The date and test result must be listed. Anyone born before 1957 must provide documentation of one vaccination for the above 3 diseases (or titers showing immunity to these disease). In lieu of vaccinations, you may be able to provide a DOCUMENTED HISTORY of the disease. This means a certificate of diagnosis as having had the disease as prepared by the physician, nurse practitioner or physician's assistant who diagnosed the disease.

A minimum of 90 days before the first clinical rotation would be needed for rubella vaccine administration and recheck of titer level if initial titers indicate non-immunity. You will NOT be permitted to attend clinical sessions until these requirements are met.

VARICELLA (Chickenpox) You must provide documentation of immunity for varicella. You may provide blood test results (titers) that demonstrate immunity to the disease, date of varicella vaccination, or date of the disease.

HEPATITIS B VACCINE - This is a 3-vaccine series that is highly recommended for health care workers. If you choose not to receive this vaccination, the waiver form on the reverse page must be signed.

TETANUS BOOSTER - You must have had within the past 10 years. If you have not, you need one before admission to the program.

INFLUENZA/H1N1 VACCINE – A seasonal flu vaccine and H1N1 vaccine is highly recommended by all healthcare agencies. Anyone who declines these vaccines must wear a mask during direct patient care.

TUBERCULIN TEST (Mantoux) – The clinical facilities require a Two-Step Mantoux skin test for any student who has not been tested on an annual basis. If the student hasn't had a Mantoux test for the last two years in a row, a second Mantoux skin test (at least two weeks after the first test) will be needed. Please indicate test dates AND test results. This is an annual test and must be within the current calendar year. If the TB test is read as positive, or the student has a prior history of a positive Mantoux, further appropriate clinical follow-up is necessary.

	Vaccination Date		Titer Date/Results
Measles	#1	#2 **OR**	
Mumps	**OR**		
Rubella	**OR**		
Hepatitis B Vaccine	1st Dose:		**OR**
	2nd Dose:		
	3rd Dose:		
Tetanus Booster – within 10 years			

	Date of Disease	Date of Vaccine	Titer Date/Results
Varicella (Chickenpox)	**OR**	**OR**	

	Vaccination Date		Vaccination Date
Influenza Vaccine – within 1 year		H1N1 Vaccine – within 1 year	

	1st Test Date	Results (Induration by mm)	2nd Test Date	Results (Induration by mm)
Tuberculin Test (Mantoux)				

I declare that the information on this form is true and correct.

_____ Date

_____ Student Signature

CATTARAUGUS-ALLEGANY BOCES
SCREENING/VACCINE REFUSAL

Hepatitis B Declination

I understand that my clinical experience carries the risk of exposure to the Hepatitis B virus. I also understand that persons who contract Hepatitis B have a risk of developing chronic hepatitis, cirrhosis of the liver, liver failure with resultant death and other less frequent chronic debilitating diseases.

I also understand that Hepatitis B may be transmitted to my spouse or sexual partner, and that it could affect my unborn child if I am pregnant.

I understand that there is a synthetic vaccine available which has minimal side effects and a very high safety profile. I have had an opportunity to review available literature about Hepatitis B, and my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent. At this time, however, I choose not to be vaccinated.

_____ _____

Student Signature Date