HEALTH PROFESSIONS

CERTIFIED NURSING ASSISTANT

Illinois Valley Community College

HEALTH INFORMATION FORM

Physical forms must be completed and returned on the first day of lecture. All information must be filled in or this form will not be accepted. Please make a copy of your completed form for your records.

NAME:_____

ADDRESS:_____

TELEPHONE:_____ SOCIAL SECURITY#:_____-_____-_____

MARITAL STATUS:_____ SEX:_____ BIRTHDATE:_____ AGE:_____

In case of emergency, please call:

NAME:_____ RELATIONSHIP:_____

TELEPHONE: Home: _____ Work:_____

NAME:_____ RELATIONSHIP:_____

TELEPHONE: Home: _____ Work:_____

YOUR PHYSICIAN:_____ TELEPHONE:_____

ADDRESS:_____

TO THE DOCTOR: This individual is a student in the Illinois Valley Community College's Certified Nursing Assistant Program. The following health information is essential.

Health Professions

Heather Seghi	815-224-0481	Heather_Seghi@ivcc.edu
Kelli Shan	815-224-0485	Kelli_Shan@ivcc.edu
Julie Dzurisin	815-224-0330	Juliana_Dzurisin@ivcc.edu

PHYSICAL EXAMINATION

Health History:

Condition	No	Yes	Treatment
Asthma	_____	_____	_____
Convulsions	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy/Seizure Disorder	_____	_____	_____
Allergies/Sensitivities	_____	_____	_____
Mental/Emotional Illness	_____	_____	_____
Physical Impairments	_____	_____	_____
Other_____	_____	_____	_____

Physical Status	Normal	Explanation of Abnormality
Vision	_____	_____
Hearing	_____	_____
Neck	_____	_____
Lung	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Extremities	_____	_____
Bones, Joints	_____	_____
Reflexes	_____	_____
Spine	_____	_____
Circulation	_____	_____
Other_____	_____	_____

Is this individual currently receiving medical treatment? No_____ Yes_____

If yes, explain:

List past and current medical conditions: _____

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Have you ever had surgery? If yes, list all past surgical procedures: _____

List all current prescriptions, over-the-counter medicines or supplement (herbal and nutritional).

Name of Medications:	Frequency of use:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies? If yes, please list all of your allergies (i.e. medicines, food, stinging insects).

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response).

	Not at all	Several Days	Over Half the days	Nearly Every Day
Feeling nervous, anxious or on edge.	0	1	2	3
Not being able to stop/control worrying	0	1	2	3
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of >3 is considered positive on either subscale [questions 1 and 2 or questions 3 and 4] for screening purposes)

General Questions Explain "yes" answers at the end of the form.	YES	NO
Do you have any concerns that you would like to discuss with your provider?		
Has a provider ever denied or restricted your participation in sports or occupation for any reason?		
Do you have any ongoing medical issues or recent illness?		
Heart Health Questions About You.	YES	NO
Have you ever passed out or nearly passed out during or after exercise?		

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Have you ever passed out or nearly passed out after sitting or laying for extended periods of time?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have heart problems?		
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?		
Do you get light-headed or feel shorter of breath during exercise?		
Have you ever had a seizure?		
Heart Health Questions About Your Family	YES	NO
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
Bone and Joint Questions	YES	NO
Have you ever had a stress fracture or any injury to a bone, muscle, ligament, joint, or tendon that causes you discomfort now?		
Medical Question	YES	NO
Do you cough wheeze, or have difficulty breathing during or after exercise?		
Are you missing a kidney, an eye, spleen, or any other organ?		
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus* aureus (MRSA)		
Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs agter being hit or falling?		
Do you worry about your weight?		
Are you trying or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods or food groups?		
Have you ever had an eating disorder?		

Explain "yes" answers here:

_____

_____

_____

_____

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Physical Examination Form

Examination		
Height:	Weight:	BP:
Pulse:	Temperature:	Respirations:
Vision R 20/	Vision L 20/	Corrected? Y/N
Medical	**Normal**	**Abnormal Findings**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapses [MVP], and aortic insufficiency.		
Eyes, Ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing auscultation supine, and +- maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
Musculoskeletal	**Normal**	**Abnormal**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		

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In order to perform the job responsibilities and tasks assigned to the students in the Certified Nursing Assistant Program, the student must be able to:

< Perform a full range of body motion including bilateral arm, hand and finger dexterity and eye-hand coordination.

< Bend, reach, pull, push, stoop, sit and walk repeatedly for extended periods of time.

< Physical mode for the clinical site is medium work.

< Exerting/lifting up to 35 pounds of force **occasionally**, and/or up to 20 pounds of force **frequently**, and/or up to 10 pounds of force **constantly** to move objects.

< Demonstrate visual and auditory acuity within a normal range (with correction, if needed)

< Maintain composure when subjected to high stress levels.

< Adapt effectively to environments with high tension to ensure patient safety.

< Respond quickly in an emotionally controlled manner in emergency situations.

< Communicate in a rational and coherent manner, both orally and in writing, with individuals of all professions and social levels.

_____ This individual is physically able to perform the activities listed above and to function as a student in the CNA program.

_____ This individual is able to function as a student in the CNA programs **WITH RESTRICTIONS**. Please indicate restrictions below.

Restrictions:

_____

_____

_____

_____

_____ _____

Physicians Signature Date

_____

Physicians Printed Name

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Student: I hereby acknowledge the information that I have provided in this form and that I have given to my healthcare provider is accurate.

_____

Students Signature

IMMUNIZATION/TESTING REQUIREMENTS

TB skin test

One of the following is required upon admission:

- Negative two-step skin test (1-3 weeks apart) administered within the past 3 months OR
- Negative QuantiFERON Gold blood test administered within the past 3 months OR
- Negative T-Spot blood test administered within the past 3 months OR
- If positive results, submit a clear chest x-ray administered within the past 2 years.

If your chest x-ray is more than 12 months old, a symptom free TB Questionnaire dated within the past 12 months is also required. If previous positive results, a symptom free TB Questionnaire. No yearly test will be required.

Two-Step Skin Test

Date: _____ Result: _____ Signature:_____

Date: _____ Result: _____ Signature:_____

QuantiFERON Gold Blood test

Date: _____ Result: _____ Signature:_____

T-Spot Blood Test

Date: _____ Result: _____ Signature:_____

If test is positive, please indicate:

1. Chest X-Ray Date: _____ Initial: _____
2. Symptom Free TB Questionnaire Date: _____ Initial: _____

To be eligible to participate in the CNA Program, you cannot have any restrictions, including but not limited to the typical physical demand requirements outlined on this form.

If you have a physical or emotional condition that required treatment by a physician that may affect your participation in any way, you must provide a release from your doctor permitting you to perform the normal activities of the program, as outlined in the physical demands section of this document and in the student handbook.

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A completed Health Information Form must be turned in to your lab instructor on the first day of class.

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