Dear Nurse Aide Program Student: *Watch w/second hand*

Attached are the required documents that must be completed to begin this program:

- Physical examination and immunization record forms.
- Background Check and Drug Screen order placement instructions.

Please begin completing the requirements below as soon as possible.

Physical Exam **Immunizations Record** **Technical Standards**	Physical exam to include vision and hearing. Please have a physician complete the attached "Physical Examination" and "Immunization Record" forms. (physical exam - approx. cost $100)
Measles, Mumps, Rubella (MMR)	One of these is required: -documentation of 2 doses of MMR vaccine at least 4 weeks apart -or a positive antibody titer for Measles, Mumps and Rubella (lab report required) Titers must include date, dose and interpretation.
COVID19 Vaccination	Clinical sites require students to be full vaccinated for COVID19. Proof of either 2 Pfizer or Moderna Vaccines or 1 Johnson & Johnson Vaccine.
Tetanus, Diphtheria, Pertussis (Tdap)	Documentation of vaccination with 1 dose of Tdap within the past 10 years. (Td not accepted)
Varicella (Chicken Pox)	One of these is required: -documentation of vaccination with 2 doses of varicella vaccine at least 4 weeks apart. -or a positive antibody titer (lab report required) Titers must include date, dose and interpretation. -or a medically documented history of disease
TB Please note this is a **2-step** TB skin test.	Documentation of a negative **2-step TB skin test. (Two separate tests done 1-3 weeks apart)** *Note: only 1-step is required if you provide documentation that you have been tested in past year.* If results are positive, provide a clear chest x-ray.
Hepatitis B *(recommended but optional).*	You are strongly encouraged to take this vaccine. One of the following is required: -documentation of a series of 3 vaccinations -or a positive antibody titer (lab report required). Titers must include date, dose and interpretation or the declination paperwork signed and uploaded -a signed declination form (available through your program director)
Influenza Vaccine (flu shot)	You will need this when it is available in the Fall semester.
CPR Certification	The required American Heart Association BLS course is included in the Nurse Aide I course - $6.00 for AHA CPR Card issued.
Criminal Background & 12-Panel Drug Screen	This is done through our clinical screening company, Castle Branch. Instructions are included on the last page of the packet. Use only the code provided, AF04.

continued

Forms of ID	An unexpired Photo ID and Social Security Card is due at Registration.
CFCC student ID badge	This badge is available at no charge at the cashier's office in Union Station 24 hours after you have registered for class.

The above documentation will be turned in to your Instructor on the first day of class.
If all of the above requirements are not completed by the first day of class, you will forfeit your seat in the Nurse Aide program, unless an extension to the first day of class document submission requirement has been approved, in advance, by the Nurse Aide Program Director.

Uniforms:

Uniforms are to be worn everyday starting on the first day of class.

- **Ceil Blue Scrubs** – (Price will vary by vendor)
    - White or blue long sleeve tee shirts may be worn under scrubs.
- **White Sneakers or Nursing Shoes**– (Price will vary by vendor)

Textbook and Workbook: Book Store, L Bldg, 1st Floor

- **Textbook and Workbook to accompany:** : Hartman's Nursing Assistant Care: Long-Term Care (5th Edition) Susan Alvare Hedman, Jetta Fuzy, RN, MS and Suzanne Rymer, MSTE, RN-BC, LSW. –$75.00 (CFCC Book Store – Prices are for new books only and are subject to change).

The NC State NA I Certification Exam:

- The NC State Test is administered by Pearson Vue at CFCC. Fee – $140.00. This fee is due at the end of the semester.

If you have any questions please email kjjordan461@mail.cfcc.edu or contact the Nurse Aide office at (910) 362-7181.

Cape Fear Community College Health Science

IMMUNIZATION RECORD – (Please print in black ink).

To be completed and signed by a healthcare provider. A complete immunization record from a healthcare provider or clinic may be used in place of this form.

____

Last Name | First Name | Middle Name | Date of Birth (mo/day/year)

REQUIRED IMMUNIZATIONS				
	mo/day/year	mo/day/year	mo/day/year	mo/day/year
Tdap	Tdap dose within last 10 years	if expired,then Td booster		
MMR 2 doses or individual doses below	Dose #1	Dose #2	or positive antibody titer for MMR (lab report required) must include date, dose and interpretation.	
Measles	Dose #1	Dose #2	or Disease Date	or Titer Date & Result
Mumps	Dose #1	Dose #2	Disease Date NOT Accepted	or Titer Date & Result
Rubella	Dose #1	Dose #2	Disease Date NOT Accepted	or Titer Date & Result
Varicella 2 doses (chicken pox)	Dose #1	Dose #2	or Disease Date	or Titer Date & Result
TB Skin Test (2-step) Tuberculin (PPD) or Gold Interferon	(1) Date given: Date read:	result in mm positive □ negative □	(2) Date given: Date read:	result in mm positive □ negative □
for positive TB **Chest x-ray**	Date:	Results:		
Influenza Vaccine (Flu)	Date:			
Hepatitis- B Series (optional but recommended)	Dose #1	Dose #2	Dose #3	or Titer Date & Result

____

Print of Physician/Physician Assistant/Nurse Practitioner | Area Code/Phone

____

Office Address | City | State | Zip Code

____

Signature or Clinic Stamp REQUIRED above

Health Science PHYSICAL EXAMINATION

(Please print in black ink) – To be completed and **signed by the Healthcare Provider**

____

Last Name First Name Middle Name Date of Birth (mo/day/year)

Height ____________ **Weight** _____________	**Date of Physical Exam:**
Temp _________ **Pulse** _______ **Respirations** _______	**Blood Pressure** __________
Vision: Corrected Right 20/_____ Left 20/_______ Uncorrected Right 20/_____ Left 20/_______ Color Vision	**Hearing**: (gross) Right Left 15 ft. Right Left

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss of seriously impaired function of any paired organ? No Yes

B. Is student under treatment for any medical or emotional condition? No Yes _ _____

C. Recommendation for physical activity Unlimited Limited ____________

Based on my assessment of this student's physical and emotional health on this date _______________, he/she appears to be able to participate in the activities of a health professional in a clinical setting and provide safe care to the public.

Yes___ No___ If no, please explain

____

Print of Physician/Physician Assistant/Nurse Practitioner Area Code/Phone

____

Office Address City State Zip Code

____

Signature or Clinic Stamp REQUIRED above

Cape Fear Community College - Nurse Aide Program
Instructions for Order Placement

When you place your initial order, you will be prompted to create your secure myCB account. From within your myCB, you will be able to: