RANDOLPH COMMUNITY COLLEGE

629 lndu trial Park Avenue • Asheboro, NC 27205 • (336) 633 0200 • www.randolph.edu

Creating Opportunities. Changing Lives.

Thank you for your interest in the Nursing Assistant 1 course at Randolph Community College. The NA 1 training course consists of classroom theory, lab instruction and a clinical externship. After satisfactory completion of this course, you should be eligible to take the NA 1 competency examination for certification.

The following courses are offered:

ASHEBORO CAMPUS NAS 3240A 87035

NA 1 **-DAV January 14th 2025-April 30th 2025**

Class/Lab T/W/Th 8:15am-12:15pm January 14th- March 2?h Room 220/222
Clinical T/W/Th 8:1Sam-12:1Spm April 1st-April 29th Various clinical sites
Class for Mock Review 8:15am-12:1Spm April 30th Room 220/222

Application deadline: November 1st 2024

Please note there are two sections include here for the application process
Section A includes information/directions for your information
Section B is the application to be completed and returned

In order to register for the Nursing Assistant 1 course, the student must submit the application - Section B with **ALL** completed paperwork and requirements. Please note the application deadline.
There is limited enrollment so getting your application in promptly is suggested.
Students are accepted on a first come - first serve basis.
Clinical days/times may involve alternate days and/or extended hours other than those regularly scheduled for class and will involve travel - reliable transportation is necessary.

No application will be processed unless it is complete.
Incomplete applications will not be returned.

The applicant is responsible to maintain their own copies of this documentation for possible use later. We will **NOT** be able to make copies of this documentation once it has been submitted.

Please call Janet Ingold at 336-633-0171 for any questions regarding this application packet.

SECTION A

Information and Instructions

PERFORMANCE STANDARDS FOR STUDENTS IN THE NURSING ASSISTANT PROGRAM

In compliance with the 1990 Americans with Disabilities Act, the following standards have been established.

The following are examples of the kind of activities, which a student in the Nursing Assistant program would be required to perform in order to successfully complete the program. If an accepted applicant believes that he/she cannot meet one or more of the standards without accommodations or modifications, the applicant should consult with the Program Coordinator.

1. Critical thinking ability sufficient for clinical judgment.
   Example: Identify cause and effect relationship in clinical situations
2. Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.
   Example: Establish a relationship with patients and colleagues.
3. Communicate with others orally and in writing.
   Example: Explain procedures, document actions, record client responses to treatment.
4. Physical abilities sufficient to move from room to room and maneuver in small spaces.
   Example: Answer calls from clients, retrieve equipment, and move about in client rooms.
5. The ability to manipulate equipment and to assist clients with physical limitations.
   Example: Use equipment, calibrate equipment, position clients, administer CPR, and insert catheters.
6. Hearing ability sufficient to monitor and assess health needs.
   Example: Hear a monitor alarm, listen to heart and breath sounds, hear a cry for help.
7. Vision sufficient for observation and assessment necessary in nursing care.
   Example: Observe client responses to treatment; see a change in skin color, read the scale on a syringe.
8. Sense of touch sufficient to perform a physical examination and to detect movement.
   Example: Detect pulsation.

The examples given are representative of those activities required and are not all-inclusive.

Guidelines for Evaluation of Physical Health

Physical health is defined as being free of disabling or contagious diseases, being able to perform fine and gross motor skills, and being able to perform normal weight-bearing activities. Initial assessment of physical health is based on a completed physical/health form. *A physical examination performed no more than six months prior to the prospective date of entry into the program is required.* This examination may be performed by a licensed physician, a registered physician's assistant, or a certified nurse practitioner. Completion of the health form for the State of North Carolina is required. If a physical health problem threatens to prevent or prevents satisfactory classroom or clinical performance the student is referred to an appropriate professional. The recommendation of the professional is utilized to advise the student regarding admission or continued enrollment. Applicants or students may be denied admission or continued enrollment until the identified problem is satisfactorily corrected.

Guidelines for Evaluation of Emotional Health

Emotional health is defined as reacting appropriately to stressful situations, coping with everyday stressors effectively, using healthy coping mechanisms, and understanding one's own ability to cope with stressful situations. Initial assessment of emotional health is based on physician information provided through the completed health form. If an emotional health problem threatens to prevent or prevents satisfactory classroom or clinical performance, the applicant or student is referred to an appropriate professional. The recommendation of the professional will be utilized to determine whether admission or continued enrollment in the program is appropriate. Applicants or students may be denied admission or continued enrollment until the identified problem is satisfactorily corrected.

Technical Standards for Nursing Assistant Program

Our program technical standards have been developed to help students understand nonacademic standards, skills, and performance requirements expected of a student in order to complete the curriculum. If an

accommodation is necessary to participate in the program, it is imperative to identify a reasonable accommodations to those students who qualify under the Americans with Disabilities Act (ADA). Reasonablenessis determined by RCC's Student Services on a case-by-case basis utilizing the program technical standards. The accommodation needs to be in place prior to the start of the program, or it may delay your ability to start the program. It is the student's responsibility to contact Tammy Cheek at 336-633-0246 or email twcheek@randolph.edu. and request accommodations.

SKILLS	DESCRIPTION	SPECIFIC EXAMPLES
MOTORSKILLS	Fine and coarse motor skills	Can stand, bend, tie, open containers, sit, push and pull equipment and furniture, lift from 10 to 50lbs., perform CPR, assist patients with AOL, monitor vital signs, do dressing changes, oxygen therapy, catheterizations, tube feedings, ostomy care.
SMELL	Adequate sense of smell	• Able to smell smoke, offensive and non-offensive odors, such as fecal and urine smells or perfume (can be offensive and cause nausea). • Can smell and recognize infectious odors.
VISION	Near and Distant vision with or without corrective lenses	Can read regular sized print, discern skin colors, shapes and sizes of injuries or lesions, determine distances such as 2 inches, 3 cm, 10 ft., 20 ft.
HEARING	No more than mild hearing loss with or without hearing aids	• Auditory ability must be sufficient to communicate/understand and give directions effectively to patients, family, and staff. • Can hear alarms from beds and monitors, patient calls, call bells, persons speaking from across the room
TECHNOLOGICAL	Can operate a computer, small equipment	Can operate equipment such as Dynamaps (vital sign monitors), CD player, use email, basic computer programs such as Excel, Word, can upload and download information
COMMUNICATION	Ability to speak coherently and appropriately	Spoken, written and electronic language is clearly understood by staff, patients, and families
CRITICALTHINKING/ PROBLEM SOLVING	Can detect abnormal or untoward situations and act or report to superiors	Can intervene using job skills/knowledge related to training/position and reports in a timely manner to superiors.
INTERPERSONALSKILLS	Tries to foster positive relationships with patients and staff	• Establishes collegial relationships with co-workers and rapport with patients, able to maintain emotional stability in negative situations remains calm and objective in crises, accepts accountability for own actions, establishes rapport with patients of diverse cultures and age groups, is respectful, empathetic, and team oriented. • Observes HIPAA regulations consistently. • Maintains a negative background check and drug screen.

ENVIRONMENTAL TOLERANCE	Can work in a less than optimal environment	• Could function in case of a fire or evacuation, with or without heat, or in case of flooding. • Ensures that infection prevention protocol prevails concerning bodily secretions, hand hygiene, odor control, and exposure to infectious persons. Protects self and patients by using personal protective equipment as applicable. • Can identify unsafe circumstances and assist in transfer or evacuation of patients.

This document is intended to *serve* as *a guide regarding the physical, emotional, intellectual and psychosocial expectations placed on a student. This document cannot include every conceivable action, task, ability or behavior that may be expected of a student. Meeting these technical standards does not guarantee employment in this field upon course completion. Ability to meet the program's technical standards does not guarantee a student's eligibility for any l/censure, certification exam, or successful completion of the program.*

ATTENDANCE STUDENTS MUST ATTEND THE FIRST DAV OF CLASS

In accordance with Federal laws that govern Nurse Aide training, the Nursing Assistant Program attendance policy is very strict for class, lab and clinical. Attendance plays a critical role in your success in the Nursing Assistant courses. Satisfactory progress is difficult without regular attendance.

*Please note that clinical externship days/times and location may vary from your class/lab schedule. You will need to have a flexible schedule and reliable transportation.

Policy on Student Medical Form and Immunizations

Student Medical Form

Each applicant for this course will be required to have the NCCCS Student Medical Form completed by a medical provider. Applicants with physical or emotional limitations should be counseled regarding the necessary skills required for successful completion of the course. After careful review of the medical form, the instructor may require that additional information from a physician be required in order for the student to complete the course. Any applicant who does not submit a NCCCS student medical form with appropriate healthcare provider documentation will not be admitted into the program. Physical examination must be completed no more than 6 months prior to the start date of the course.

Immunizations

Each applicant for admission to the Nursing Assistant Program will be required to submit proof of specific immunizations and/or tests. These include (but may not be limited to):

- **MMR-** two immunizations or positive titers for measles (rubeola), mumps and rubella
- **Varicella** - two immunizations or positive varicella titer
- **Hepatitis B-** completed set of three vaccines or positive HBV titer or signed waiver
- **Tetanus** - current booster within the last two years or one dose Tdap
- **TB skin test-** within the last 12 months with negative results or negative chest x-ray
- **Flu Vaccine** -from most recent flu season (October-March)
- **COVID 19 Vaccinations RECOMMENDED-** (provide proof if you have received these)

Please note there are immunizations required that are in lieu of the ones listed on the NCCCS student medical form. These immunizations are required by our clinical facilities for students practicing in their clinical setting. Show this list to your physician or clinic when you give them the NCCCS student medical form.

Any applicant who does not submit the required immunization documentation will notbe admitted into the program.

CPR Healthcare Provider-ALL classes are held at our Asheboro campus and are $80.00

This course is designed for individuals who work in a healthcare setting (doctor's office, hospital, EMT, Paramedic, nursing facility, home health care, etc.). Students will learn to recognize several life-threatening emergencies, provide CPR to victims of all ages, use an AED and relieve choking in a safe, timely and effective manner.

Day Classes Meet 9am-lpm	Night Classes Meet 5pm-9pm
January 16th Tuesday 84766 (Kivett)	January 3rd Wednesday 84765 (Gaddy) January 18th Thursday 84767 (King)
February 20th Tuesday 84769 (Barr)	February 7th Wednesday 84768 (Gaddy) Februarv 22nd Thursday-Hispanic 84770 (Benitez)
March 19th Tuesday 84773 (Kivett)	March 13th Wednesday 84772 (Gaddy) March 21st Thursday 84774 (King)
April 16th Tuesday 84776 (Barr)	April 10th Wednesday 84775 (Gaddy) April **18th** Thursday-Hispanic 84777 (Benitez)
May 14th Tuesday 84779 (Kivett)	May 8th Wednesday 84778 (Gaddy) May 16lh Thursday 84780 (King)
June 18th Tuesday 84782 (Barr)	June 12th Wednesday 84781 (Gaddy) June 20th Thursday-Hispanic 84783 (Benitez)
July 16th Tuesday 84785 (Kivett)	July 10th Wednesday 84784 (Gaddy) July 18th Thursday 84786 (King)
August 20th Tuesday 84788 (Barr)	August 14th Wednesday 84787 (Gaddy) August 22nd Thursday-Hispanic 84789 (Benitez)
September 17th Tuesday 84791 (Kivett)	September 11th Wednesday 84790 (Gaddy) September 19th Thursday 84792 (King)
October 15th Tuesday 84795 (Barr)	October 9th Wednesday 84794 (Gaddy) October 17th Thursday-Hispanic 84796 (Benitez)
November 19th Tuesday 84798 (Kivett)	November 13th Wednesday 84797 (Gaddy) November 21st Thursday 84799 (King)
December 10th Tuesday 84801 (Barr)	December 4th Wednesday 84800 (Gaddy) December 12th Thursday-Hispanic 84802 (Benitez)

SECTIONB

Must be completed in black ink and returned

Application for **Nursing Assistant** I

Please **PRINT** - Complete in **Black INK**

Full Name .....
First *Middle/Maiden* *Last*

Student ID# or SS# .....

Address .....

City _____ State _____ Zip _____

E-Mail address: _____

Phone: Mobile _____ Date of Birth _____

Course Code # .....
(see *cover letter for available choice)*

Admission Requirements: Enclose each completed requirement with application

- Copy of Government issued photo ID (name *must match)*
- Copy of Government issued Social Security card *(name must match)*
- Copy of High School Diploma or GED
- Proof of current Health Care Provider BLS CPR certification from American Heart Association
- NCCCS Student Medical Form by medical provider
- Immunization Record (see *attached policy and documents)*
  - Two MMR vaccines or positive titer
  - Two Varicella vaccines or positive titer
  - Three Hepatitis B vaccines, positive titer or signed waiver
  - Current tetanus immunization
  - Current TB skin test
  - Current Flu Vaccine (current season - October-March)
  - COVID 19 Vaccinations recornmended-(provide proof if you have received these)
- Criminal background information form *(signed)*
- Documentation of reading test scores *(see attached form)*

Applicant Signature _____

Applicant Printed Name _____

Date _____

No application will be processed unless it is complete.
Incomplete applications will not be returned,
Keep copies ofrecords submitted for possible use at a later date.
Once documentation is submitted with this application, we will **NOT** be able to duplicate it for you.

Received date: _____

Completion date: _____

RANDOLPH
COMMUNITY COIJ.ECE

Randolph Community College

629 Industrial Park Ave., Asheboro NC 27205 / www.randolph.edu

CONTINUING EDUCATION STUDENT REGISTRATION FORM

NAME (Please Print) NOMBRE Last/ Apellido	First / Nombre	Middle/ Segundo Nombre	Maiden/ Nombre de soltera

Address/ Direcci6n	City/ Ciudad	State/ Estado	Zip/ C6digo	County/ Condado

Home Phone# Telefono de casa	Work Phone# Telefono de trabajo	Cell Phone# Numero de telefono de celular	Social Security Number or your 7-digit Student ID Number Numero de Seguro Social/ o numero de estudiante de 7 dlgitos ☐☐☐☐☐☐☐☐☐

E-mail Address / Correo Electr6nico

Date of Birth/ Fecha de Nacimiento

☐☐-☐☐-☐☐

Employment Status - Circle One/ Estado de empleo - Circule uno

E1 - Employed/Empleado 1-10 H .
E2 • Employed/ Emp!Hekl11-20 rs.
E3 - Employ•d/ Emp ado 2 1-31>Hr..
E4 • Employed 40 or more Hts.
Empleado 40 hrs o mas
R • R1tirtd/RetiridO
US- Unemployed See g/ Susc.ando emp o
lfN • Unemployed • Not liH ng
Oeiampludo - No buliCilndo

Name of Employer/ Nombre de empleador _____

Ethnic - Circle One / Etnicidad
l. Non-Hispanic/Latino
2. Hispanic/Latino

Race - Circle One/ Raza - Circule uno
l. American/Alaskan Native
2. Asian
3. Black or African American
4. Hawaiian/Pacific Island
5. White
6. Other

Gender - Circle One
Genero - Circule uno
M - Male/ Masculino
F - Female/ Femenina

Circle highest grade completed or check if passed High School (HS) Equivalency (GED) D
I 2 3 4 5 6 7 8 9 JO 1I 12 13-Adult HS Diploma
Circule el grado mas alto completado, o marque si aprob6 equivalencia de escuela secundaria

14- One Year Vocational Diploma 15-Associatc's Degree 16-Bachclor's Degree 17-Master's Degree or higher
14- Diploma Vocacional de un ailo 15-Titulo asociado 16-Licenciatura 17-Maestria o mas alto

How did you learn about the class?
lC6mo te enteraste **de** la clase?

Section Number Ex: CAS3020A 98000	**Section Title** Introduction to Computers	**Day(s)** T,Th	**Time** 6-9 pm	**Fees** $125	**Location** Main Camous
l.					
2.					

Signature/Firma _____ Date/Fecha _____ Amount Paid/ Cantidad pagada _____

For CE Registration Only/ S61o para registro CE
Method of Payment: __ Cash Check Credit Card

Revised 3/29/24 kwt

Randolph Community College

(336) 633-0200 www.randolph.edu

Student Medical Form for North Carolina Community College System Institutions

Please keep copies of records submitted for possible use at a later date. Once documentation is submitted with this application, we will NOT be able to duplicate it for you.

REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

LAST NAME (print) | FIRST NAME | MIDDLE/MAIDEN NAME | LAST 4 DIGITS SOCIAL SECURITY NUMBER

PERMANENT ADDRESS NUMBER | CITY | STATE | ZIP CODE | AREA CODE/PHONE

DATE OF BIRTH (mo/day/yr)_____ GENDER ☐ M ☐ F MARITAL STATUS ☐ s ☐ MD OTHER EMAIL._____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)

NAME OF POLICY HOLDER | EMPLOYER

POLICY OR CERTIFICATE NUMBER | GROUP NUMBER | IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY | RELATIONSHIP (MUST NOT BE BOYFRIEND/GIRLFRIEND/FIANCE/FRIEND)

ADDRESS | CITY | STATE | ZIP CODE | AREA CODE/PHONE NUMBER

Is it Ok to contact above person in the event of an emergency? YES __ NO

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY (Please print in black Ink) To be completed by student

	Yes	No	Relationshio
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clottina disorder			
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			
Cancer (type):			
Alcohol/drua oroblems			
Psychiatric illness			
Suicide			
Other /SoeciM			

HEIGHT _____ __ WEIGHT _____ __

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in .-h,.d			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation reatm..nts			
rumor or cancer """"CiM			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			
Hay fever			
Allergy injection .1,.,..nv			
I\rthritis			
Concussion			
i=requent or severe """""""""h"			
Dizziness or fainting ,n..ns			
Severe head injury			
Paralysis			
Disabling depression			
EXcessive worry or nxietv			
JIcer (duodenal or stomach)			
ntestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or o::ill"InM			
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent labdomlnal oain			
Hernia			
Easy fatigability			
nemia or Sickle Cell lAnemia			
Eye trouble besides In""rl DI"""""""			
Bone, Joint, or other H1>formitv			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone soecifv\			
Kidney infection			
ladder infection			
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual .,.,.mne			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack /Week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please 11st any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____ __

FAIIIL:Y & PERSONAL HSALTff!tl$TORY-CONTINUED• {Please prfntlil btack.Jt:lk} .To ts. mpfetee student

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Exolanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and whv)			
Has your academic career been interrupted due to physical or emotional problems? (Please exolainl			
Is there loss or seriously impaired function of any paired oraans? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION,.... PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(8) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. **(Not applicable to community colleges.)**

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. **(Not applicable to community colleges.)**

Signature of Student Date

Signature of Parent/Guardian, if student under age 18 Date

GUIDELINES.FOR COMPLETIHGJMMUNIZATION RECORD ANIJ TB SCREENING

IMPORTANT - The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Please review information noted in each section prior to entering information
Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.)**

- High School/Previous College/University Records - These may contain some, but not all of your immunization information. Contact Student Services for help if needed. Your immunization records do not transfer automatically. You must request a copy.
- Personal Shot Records - Must be verified by a doctor's signature or by a clinic or health department stamp, including a printout from any Immunizations Registry.
- Military Records or WHO (World Health Organization Documents)

IMMUNIZATION REQUIREMENTS ACCORDING TO AGE

STUDENTS 17 YEARS OF AGE AND YOUNGER				
Tdap	Polio	Measles[2]	Mumps[4]	Rubella[4]
Every 1O years	3	2	1	1
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER				
Tdap	Polio	Measles[2,3]	Mumps[4]	Rubella[4]
Every 10 years	0	2	1	1
STUDENTS BORN BEFORE 1957				
Tdap	Polio	Measles	Mumps	Rubella[4]
Every 10 years	0	0	0	1
STUDENTS 50 YEARS OF AGE AND OLDER				
Tdap	Polio	Measles	Mumps	Rubella
Every 1O years	0	0	0	0
INTERNATIONAL STUDENTS				
Vaccine Required				
Vaccines are required according to age (refer to appropriate box). Additionally, students are required to have two TB skin tests with negative results within the 12 months preceding the first day of classes (chest x-ray required if test is positive).				

1. DTP (Diphtheria, Tetanus, Pertussis): One Tdap (Diphtheria, Tetanus, Pertussis) within the last ten years
2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

SCREENING/DIAGNOSTIC TESTS:

TB Skin Tests: 2 tests performed within the last year (administered and read by a nurse, NP, PA, or physician). Must read O mm or No Induration. Quantiferon Gold (If accepted by admitting program) must show numeric result. If positive result from TB Skin Test or Quanitferon Gold, chest x-ray is required and must be updated every year while in the admitting program. Results of chest x-ray must be documented by doctor and submitted for admission and progression in the program.

SECTION B: These vaccines are **RECOMMENDED** Some may be required by certain departments. Consult your college or department for specific requiren

IMMUNIZAtIONRECORD

print In black In plated an fIgned by physician. A com leti immunIZatIon be•ttached to this form.

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Last 4 Digits of Social Security Number

REQUIRED IMMUNIZATIONS AND TB SCREENING (DO NOT WRITE IN SHADED AREAS)

	mo./day/ year (#1)	mo./day/ year (#2)	mo./day/ year (#3)	Titer Date, Numeric Result, and _e of Immunity
• Tdap				
• MMR (after first birthday) Series of 2 vaccinations or immunity by positive blood titer for each of the below com onents				
• **MR** (after first birthday)				
• Measles (after first birthday)				
• Mumps				
• Rubella				
• Hepatitis B series only (series of 3 vaccinations or immuni b ositive blood titer				
• Varicella (chicken pox) series of two doses or immuni b ositive blood titer				
• Tuberculin (PPD) Test Date read 2 tests within 12 months mm induration				
• QuantiFERON Gold Titer				
Chest x-ray, if positive PPD • Attach results report Attach Results				
• Treatment if applicable Date				
• Influenza (Current Season)				

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Menl _oeoccal = - -- ReceiVed the meni- oeoccal vaccineTNs **Yes**

If **Yes**, please indicate date(s) vaccine was received (mo./day/year)

•• OPTIONAL IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year
• Haemophilus influenzae type b			
• Pneumococca l			
• Heoatitis A series only			

Signatur e/Clinic Stamp REQUIR ED:

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

"* Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable,but must have signed statement from physician.
Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.•••Attach lab report.

PHYSICAL ***EXAM/NATION*** *(Please print in black ink) To be completed and* ***signed*** *by physician*

A physical examination is required. It must be completed in black ink and signed by a physician.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	Last 4 Di its of Social Securi Number

Permanent Address	Cltv	State	ZioCode	Area Code/Phone Number

Height ___ _ Weight._____ __ TPR ____ •____•____ BP _____/____

ALL SECTIONS REQUIRED:	ALL SECTIONS REQUIRED:
Vision: Corrected Right 20/ __ _ Left 20/ Uncorrected Right 20/ __ Left20/ Color Vision _____ __	Hearing: (gross) 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 or seriously impaired function of any paired organs? Yes ___ _ No ___ _
Explain _____

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

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited ___ _ Limited ___ _
Explain _____

D. Is student physically and emotionally healthy? Yes ___ _ No _____ __
Explain _____

• REQUIRED FOR ALL STUDENTS•

Based on my assessment of this student's physical and emotional health on _____,he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain ___ _
(Date)

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip**

RANDOLPH COMMUNITY COLLEGE
Nursing Assistant Program

Information RegardingCriminal Background Check/Drug Screen for Clinical Externships

Affiliating clinical agencies require a national criminal background check and drug screen as a prerequisite for clinical learning experiences. Positive results can result in clinical agency denying the student access to clinical practice in the facility. Any student who is denied access to any clinical facility will not be allowed to progress in the program. Students are responsible for all fees associated with background check/drug screen. You are signing this form as acknowledgement of this requirement of the program.

Potential students should be aware that this will be their financial responsibility.
Drug Screening- approximately $40.00
Criminal Background Check - $60.00 & up - depending on searches

Do **NOT** obtain this criminal background check or drug screening prior to starting the course.

My signature below indicates that am aware of the information regarding the national criminal background check and drug screen being required. I understand that if I fail to meet certain criteria, as set by these facilities, that I may not be able to participate in clinical education and that this may prevent my successful completion of the course/program to which I am applying.

Signature _____ __

Print Name._____ __

Date._____ __

Student ID#_____ __

RANDOLPH COMMUNITY COLLEGE
Nursing Assistant Program

Reading Assessment Verification

Appointments are required for testing. Limited same day testing may be available.

Asheboro Campus: Call (336) 633 - 0200 or (336) 633 - 0321

Archdale Center: Call (336) 862 -7980

Appointments are available mornings, afternoons, and evenings

Location: Assessment Center (next to the greenhouses; behind the Campus Store)

Acceptable scores/ courses:
Reading: COMPASS Reading- score of 81 or higher

NCDAP (Accuplacer)- score of 117 or higher

TABE-585

Completion of Eng 011 or higher, with a grade of C or better

If you intend to use scores from testing done at another school, please see the Welcome Center to have those scores transferred officially to RCC - we cannot accept a print-out of scores. Take this form with you to your testing appointment.

Please ensure that someone from the Assessment Center signs this form.

Student Name.....

Student ID.....

Date.....

Test Type _____

Scores *I* Completed Courses _____ __

_____

Assessment Center Signature _____ __