Triton College
Certified Nursing Assistant Program Requirements

The following requirements are to be completed, reviewed by and turned in to the Health Services Department **within *30 days of the date that this packet is due. The due date is determined by your program coordinator*.**

Submit Packet to Triton College Health Services
Location: Building G (G-109)
Phone No: (708) 456-0300 x 3051
Hours: Monday - Friday: 8:30 a.m. to 4:00 p.m.

C.N.A. Requirements:

Completed by: Medical Provider

1. **"School" Physical Exam** – see attached form
2. **2 step Tuberculosis (TB) test** – see attached form
   ~ OR~
   Quantiferon Gold Blood Test – attach laboratory result
   - For students who test positive for TB tests
   - For students who previously received a BCG vaccine
   - For students who prefer to have their TB requirement drawn by blood

Completed by: Student

3. **Hospitalization Insurance** - Health Insurance Card & kept current throughout program
4. **Hepatitis B –** Titer or Waiver
5. **Tetanus, Diphtheria, and Pertussis (TDaP) –** Injection or Waiver
6. **Authorization for Release of Information Form** – completed by the student
7. **Indemnification and Release Form** – completed by the student
8. **Confidential Medical History Form** – completed by the student

Triton College - C.N.A. Program Checklist

Last Name First Name Semester Beginning

_____ School Physical Exam

_____ 2 step Tuberculosis (TB) test – or – Equivalent

_____ Hospitalization Insurance (Type): _____

_____ Hepatitis B - Titer or Waiver

_____ Tetanus, Diphtheria, and Pertussis (Tdap) – Injection or Waiver

_____ Authorization for Release of Information Form

_____ Indemnification and Release Form

_____ Confidential Medical History Form

Reviewed by: _____ Date: _____

Copy given to student: _____ Date: _____

Additional copies given to students are $10.00

Revised: 04/18

School Physical Examination

To be completed within 30 days of the due date

Last Name **First Name** **Middle Initial**

	Normal	Abnormal	Comments
1. General Appearance			
2. Skin			
3. Eyes			
4. Ears/Nose/Throat			
5. Hearing			
6. Lymph Nodes			
7. Respiratory			
8. Cardiovascular			
Blood Pressure			
Pulse			
9. Abdomen/G.I.			
10. Musculoskeletal			
11. Joints/Extremities			
12. Neurological			
13. Metabolic/Endocrine			
14. Other			

Is the student receiving medication or treatment for any health-related problems that may impair his/her ability to perform their clinical duties safely?
Yes_____ No_____ If Yes; list and indicate if the student may/may not perform clinical duties with/without restriction or limitation.

_____

_____

Does the student have restrictions or limitations in performing their clinical duties safely?
Yes_____ No_____ If Yes; list and indicate if the student may/may not perform clinical duties with/without restriction or limitation.

_____

_____

Physician Signature: _____ Date: _____

Health Care Provider Stamp

Revised: 04/18

2 Step Tuberculosis Test or Quantiferon Gold Blood Test

To be completed within 30 days of the due date & kept current annually

Last Name **First Name** **Middle Initial**

2 Step TB Test

- **The First TB Test** is given & read by the same health care facility within 48-72 hours.
  ***Note – if you are in need of a **LIVE VACCINE; IT MUST NOT BE ADMINISTERD ON THE SAME DAY AS THE 1st TB INJECTION**.

- **The Second TB Test** is to be completed within 7 to 21 days from the First TB Test. It is given & read by the same health care facility within 48-72 hours.

Have you ever had a positive TB test? **Yes ___ No ___**

Have you ever had a BCG injection? **Yes ___ No ___**

TB step 1:
Date Given: _____ Time Given _____ Lot No. _____ R. /L. Forearm Nurse: _____

Date Read: _____ Time Read _____Results _____ Nurse: _____

TB step 2:
Date Given: _____ Time Given _____ Lot No. _____ R. /L. Forearm Nurse: _____

Date Read: _____ Time Read _____Results _____ Nurse: _____

TB Update:
Date Given: _____ Time Given _____ Lot No. _____ R. /L. Forearm Nurse: _____

Date Read: _____ Time Read _____Results _____ Nurse: _____

Quantiferon Gold Blood Test - attach laboratory results

- For students who test positive for TB tests
- For students who previously received a BCG vaccine, as this identifies latent TB, which a CXR cannot.

Health Care Provider Stamp

Hepatitis B - Release of Liability

According to the Center for Disease Control (2003) Hepatitis B is caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

In 2003, an estimated 73,000 people were infected with HBV. People of all ages get hepatitis B and about 5,000 die per year of sickness caused by HBV.

HBV is spread when blood from an infected person enters the body of a person who is not infected. Healthcare personnel who have received hepatitis B vaccine and developed immunity to the virus are at virtually no risk for infection.

Retrieved From: *http://www.cdc.gov/ncidod/dhqp/bp_hepatitisb.html*

* *

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. Hepatitis B Virus infection is a serious health problem which affects many health care providers and can lead to lengthy illness, hospitalization, and possibly, an untimely death.

I have also been informed of the benefits of Hepatitis B Vaccine, the side effects of Hepatitis B Vaccine, and also of the modes of transmission of HBV.

Although required by the health program in which I am enrolled, I decline the Hepatitis B vaccination at this time. I understand by declining this vaccine I continue to be a risk of contracting Hepatitis B.

I personally assume the risks and consequences of my refusal, and I release for myself, my heirs, executors, administrator, or personal representatives Triton College, its officers, agents and employees from any and all liability for ill effects, including death or disability, which may result from contracting Hepatitis B virus infection.

I acknowledge that I have been thoroughly informed and I understand the implications of declining the Hepatitis B vaccine.

Student Signature Guardian Signature Relationship to the Student **Date**

Those who cannot show proof of an "Immune" Hepatitis B Titer must sign this waiver.

Revised: 04/18

Tetanus/Diphtheria/Pertussis (TDaP) – Release of Liability

The American College Health Association and the Center for Disease Control and Prevention (CDC), recommends that institutions that train health care professionals, deliver healthcare, or provide laboratory or other medical support services require students to be vaccinated against Tetanus, Diphtheria, and Pertussis (Tdap).

The Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine can protect you against all three of these serious diseases.

Tetanus, diphtheria, and Pertussis are all caused by bacteria. Diphtheria and Pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds.

Tetanus (Lockjaw) causes painful tightening of the muscles, usually all over the body. It can lead to "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in up to 2 cases out of 10.

Diptheria causes a thick covering in the back of the throat. It can lead to breathing problems, paralysis, heart failure, and even death.

Pertussis (Whooping Cough) causes severe coughing spells, vomiting, and disturbed sleep. It can lead to weight loss, incontinence, rib fractures and passing out from violent coughing, pneumonia, and hospitalization due to complications.

* *

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the Tetanus, Diphtheria, and Pertussis infections.

I have been informed of the benefits of the Tdap vaccine, the side effects of the vaccine, and the modes of transmission of Tetanus, Diptheria and Pertussis.

Although required by the health program in which I am enrolled, I decline the Tdap vaccination at this time. I understand by declining this vaccine, I continue to be a risk of acquiring the Tetanus, Diphtheria, and Pertussis infections.

I personally assume the risks and consequences of my refusal, and I release for myself, my heirs, executors, administrator, or personal representatives Triton College, its officers, agents and employees from any and all liability for ill effects, including death or disability, which may result from contracting the Tetanus, Diphtheria, and Pertussis infections.

I acknowledge that I have been thoroughly informed and I understand the implications of declining the Tdap vaccine.

Student Signature Guardian Signature Relationship to the Student **Date**

Those who cannot show proof of TDaP Vaccination within the last 10 years must sign this waiver

Revised: 04/18

Authorization for Release and/or Exchange of Health Information

I, _____, authorize Triton College's Health Services Department to release and/or exchange the following information about me (check one):

☐ Any information in my health services record.
☐ Other (please specify) _____
_____

Person or agency with which Triton College Health Services may exchange information:

☐ Person/Agency: Triton College/Clinical Sites/CCMSI/Guardian/Personal Healthcare Providers/Illinois State Police Bureau of Identification/U.S. Department of Justice Federal Bureau of Investigation
☐ Other: _____

THIS CONSENT IS VALID UNTIL (check one):

☐ The completion of my academic career at Triton College
☐ Specific date_____/_____/_____

I understand that I may revoke this consent at any time and that the above named person/agency with which Health Services is authorized to exchange information has the right to inspect or copy the information to be disclosed.

It has been explained to me and I understand that if I refuse to consent to this release of information, the Triton College Health Services staff's ability to assist me may be hindered.

By signing this release, I further agree to hold harmless and indemnify Triton College, its officers, agents, trustees and employees against any losses, damages, judgments, claims, expenses, costs and liabilities imposed upon or incurred by or asserted against Triton College, its officers, agents, trustees or employees, including reasonable attorneys' fees and expenses, arising out of a release of health information consistent with this Release Form.

Student Signature Guardian Signature Relationship to the Student **Date**

Witness signature **Date**

NOTE TO PERSON/AGENCY EXCHANGING INFORMATION; under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act you may not re-disclose any of this information unless the above signed client specifically consents to such disclosure. Under the Federal Act of July 1, 1975, confidentiality of alcohol and drug abuse patient records, no such records or information from such records may be further disclosed without specific authorization for such re-disclosure.

Indemnification and Release Form

I, _____, agree to hold harmless and indemnify Triton College, its officers, agents, trustees and employees against any losses, damages, judgments, claims, injuries, expenses, costs and liabilities imposed upon or incurred by or asserted against Triton College, its officers, agents, trustees or employees, including reasonable attorneys' fees and expenses, arising out of my acts or omissions while participating in my clinical rotation as a part of my educational program at Triton College.

I fully release Triton College and shall assume all such costs, losses, damages, injuries, claims, demands and expenses of any lawsuit, legal proceeding, defense or settlement. Additionally, I shall pay all judgments entered in any such suit or other legal proceedings.

My obligations under this indemnity and release form shall continue and remain in full force and effect beyond the conclusion of the clinical rotation and Triton College's academic year.

Student Signature	Guardian Signature	Relationship to the Student	**Date**

Witness signature	**Date**

Revised: 04/18

Triton College - Confidential Medical History

Have you had/ Do you have	Yes	No		Yes	No		Yes	No		Yes	No
Rheumatic Fever			Lung Disease			Stomach Problems			Back Problems		
Scarlet Fever			Tuberculosis			Bowel/Colon Problems			Knee Problems		
Mumps			Asthma			Recent weight Gain			Ankle/Foot Problems		
Rubella (German Measles)			Chronic Cough			Recent weight Loss			Wrist Problems		
Rubeola (Measles)			Hay fever			Seizures/Epilepsy			Elbow Problems		
Varicella (Chicken Pox)			Sinus Problems			Dizziness			Shoulder Problems		
Epilepsy			Seasonal Allergies			Fainting			Arthritis		
Head Injury			Heart Disease			Depression			Weakness		
Stroke			High Blood Pressure			Anxiety			Paralysis		
Migraine			Low Blood Pressure			Insomnia			S.T.D.'s		
Gallbladder Problems			Pain/Pressure in Chest			Mental Illness			Surgery		
Liver Disease			Heart Palpitations			Eye Problems			Cancer/Tumor		
Hepatitis			Kidney Disease			Ear Problems			Food/Rx Allergies		
Jaundice			Frequent Urination			Nose Problems					
Pancreatitis			Bone Problems			Throat Problems			Other		
Diabetes			Joint Problems			Gum/Teeth Problems					

If you have answered yes to any of the above please explain on a separate sheet of paper

1. Which diagnosis you had/have?
2. When you were diagnosed with the medical condition?
3. List any treatment you had or are currently undergoing for the medical condition.

_____

Signature Guardian Signature Relationship to the Student **Date**

Revised: 04/18

Triton College - Confidential Medical History

_____C.N.A._____

Last Name First Name Middle Initial Health Career Program

_____

Address City State Zip Code

Date of Birth_____ Height_____ Weight_____ Drug Allergies_____Phone_____

In case of an Emergency please notify: _____Relationship_____Phone_____

Are you fit to perform clinical duties required of you, physically, emotionally and mentally, with or without a reasonable accommodations, when assigned to patients in multiple participating health care settings? Yes No

If you require accommodations, provide a statement from your medical provider stating the type of accommodations necessary to fulfill your clinical rotations in a safe manner.

Medications you are currently taking: _____

Are you Pregnant? Yes No N/A

If yes, do you have any restrictions related to your pregnancy? Yes No N/A

If yes, provide a statement from your medical provider regarding your restrictions and the type of accommodations necessary to fulfill your clinical rotations in a safe manner.

I am aware of the physical, emotional and mental requirements of the allied health program in which I am enrolled and certify that my confidential medical history given to both Triton College and my Medical Doctor is both current and accurate. I understand that any false answers or statements made by me in this application will be grounds for immediate dismissal from my enrollment in the Health Career program in which I am enrolled.

_____

Signature Guardian Signature Relationship to the Student **Date**

Health Requirement Information

Physicals

You are required to have a "school physical" which is less comprehensive than a traditional "adult physical". School Physicals are valid for 2 years, while in the same health career program.

Quantiferon Gold Blood Test/BCG Vaccines/Positive TB Tests

Many people born outside of the United States have received a BCG vaccine, which may cause a false positive reaction to a TB skin test. A positive reaction to a TB skin test may be due to either the BCG vaccine or to infection with the TB bacteria. Quantiferon Gold Blood testing is the preferred method of TB testing for people who have received the BCG vaccine.

Hospitalization Insurance

You are responsible for continuous health and hospitalization insurance coverage during your enrollment in the program. You must provide proof of your insurance to the Health Services Nurse, i.e., insurance card or print out of coverage.

Medical & Psychological Conditions/Pregnancy & Postpartum

Students who have a medical and/or psychological condition (including lifting restrictions/pregnancy/postpartum period) which requires reasonable accommodation to participate in clinical rotations must provide written documentation from a treating provider regarding the condition and the necessary accommodation required to allow for participation in the classroom and clinical components of the program.

Health Requirement Resources

prices and services are subject to change without notice

Physical/TB or Equivalent

Concentra/U.S. HealthWorks Medical Group

4200 N. Mannheim Rd. Schiller Park, Phone: 847-801-5170

Physical	$48	**TB or Equivalent**	
		2 TB Test's	$34
		Quantiferon Gold	$155

Elmhurst Memorial Occupational Health Services

1200 S. York St. Elmhurst 331- 221-0570

Physical	$89	**TB or Equivalent**	
		TB Test	$28
		Quantiferon Gold	$80

Advocate Occupational Health

7255 N. Caldwell Niles, Phone: 847-647-0355

Physical	$58	**TB or Equivalent**	
		TB Test	$33
		Quantiferon Gold	$81

Walgreens - Take Care Health Clinic

Central Phone: 866-825-3227

Physical	$70	**TB or Equivalent**	
		TB Test	$22
		Quantiferon Gold	

CVS Pharmacy – Minute Clinic

Central Phone: 866-389-2727

Physical	$89	**TB or Equivalent**	
		TB Test	$65
		Quantiferon Gold	

Hospitalization Insurance

*****HEALTH & HOSPITALIZATION INSURANCE IS REQUIRED*****
*****Submit your health insurance card to Health Services*****

Name	**Website**	**Phone**
Health Insurance Marketplace	http://www.healthcare.gov/marketplace	(800) 318-2596
First Agency, Inc.	http://www.1stagency.com	~ For more information call ~ (269) 381-6630

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