

****ALL INFORMATION MUST BE FILLED IN OR THIS FORM WILL NOT BE ACCEPTED!
(PLEASE MAKE A COPY FOR YOUR RECORDS BEFORE TURNING IN)
ILLINOIS VALLEY COMMUNITY COLLEGE
CNA PROGRAM**

**HEALTH INFORMATION FORM
CNA Student**

NOTE: Physical forms **Must** be completed and return to your clinical instructor.

NAME: _____
 Last First Middle

ADDRESS: _____
 Street City Zip

HOME PHONE _____ CELL PHONE: _____

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

In Case of Emergency, Please Call:

NAME: _____ RELATIONSHIP: _____

TELEPHONE: Home: _____ Cell: _____

NAME: _____ RELATIONSHIP: _____

TELEPHONE: Home: _____ Cell: _____

PHYSICIAN: _____ TELEPHONE: _____

ADDRESS: _____

DATE: _____

NAME: _____

TO THE DOCTOR: This individual is an applicant for the Illinois Valley Community College CNA Program. The following health information is essential.

PHYSICAL EXAMINATION

Health History

<u>Condition:</u>	<u>No</u>	<u>Yes</u>	<u>Treatment</u>
Asthma	_____	_____	_____
Convulsions	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy/Seizure Disorder	_____	_____	_____
Allergies/Sensitivities	_____	_____	_____
Mental/Emotional Illness	_____	_____	_____
Physical Impairments	_____	_____	_____
Other _____	_____	_____	_____

<u>Physical Status (General)</u>	Normal	Explanation of Abnormality
Lung	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Circulation	_____	_____
Skin (active/persistent conditions)	_____	_____

Physical Status (Specific)

Vision:

Requirements: Vision is required to prepare and analyze data. Using measuring devices, assembly of small parts, visual inspection, and normal color perception are also requirements.

Can be corrected to 20/40 _____

Vision Meets Requirements _____

Explanation of Abnormality _____

Hearing:

Requirements: Must perceive forced whispered voice greater than or equal to 5 ft with or without hearing aid.

Hearing meets requirements _____

Corrective devices used _____ **type** _____

Explanation of abnormality _____

Typical Physical Demands:

Requirements: Requires full range of body motion, including manual and finger dexterity with eye/hand coordination. Frequent walking, bending, sitting, and standing for extended periods of time. Physical mode for the clinical site is medium work. That is, 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.

The previous requirements include an assessment of the:

Normal

Neck	_____
Bones/Joints	_____
Reflexes	_____
Spine	_____

Meets physical requirements stated above _____

Explanations of abnormality _____

Is this individual under any medical treatment? No _____ Yes _____

If yes, please explain:

Medications: Name: _____

How often: _____

_____ This individual is physically able to function as a student in the CNA Program.

_____ This individual has **RESTRICTIONS (see note below)**.

Please indicate restrictions: _____

Physician's Signature: _____

Date: _____

Physician's printed Name: _____

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

Student Signature _____

NAME: _____

IMMUNIZATION/TESTING REQUIREMENTS

ONE STEP T.B. SKIN TEST:

Date _____ Result _____ Signature: _____

TWO STEP T.B. TEST:

Date: _____ Result: _____ Signature: _____

Date: _____ Result: _____ Signature: _____

If positive test, please indicate:

1. Evaluation to rule out active disease: Date: _____ Initial: _____
2. Education regarding signs, symptoms, treatment of active disease: Date: _____ Initial: _____

- ❖ **TO BE ELIGIBLE TO PARTICIPATE IN THE CNA PROGRAM YOU CAN NOT HAVE ANY RESTRICTIONS, INCLUDING BUT NOT LIMITED TO THE TYPICAL PHYSICAL DEMANDS REQUIREMENTS AS STATED ON THE PHYSICAL EXAM FORM .**
- ❖ **IF YOU ARE PREGNANT YOU WILL NEED A RELEASE FROM YOUR OBSTETRICIAN AND PRESENT IT TO YOUR CLINICAL INSTRUCTOR ON THE FIRST DAY OF CLASS. IF YOU HAVE ANY RESTRICTIONS YOU WILL NOT BE ABLE TO PARTICIPATE IN THE CNA PROGRAM AT THIS TIME**

Dear Examiner,

Please return the original completed physical form and TB results to the student. The only results that we are requesting to be faxed or emailed to us is the 10 panel drug screen.

Fax: 815-224-0486 email: christine_blaydes@ivcc.edu

Thank you.