**RANDOLPH COMMUNITY COLLEGE**

629 Industrial Park Avenue• Asheboro, NC 27205 • (336) 633-0200 • [www.randolph.edu](http://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 90038

### NA 1- DAY January 13, 2026- April 29, 2026

Class/Lab T-TH 8:15am-12:15pm Jan. 13-Mar. 26

Room 220/222

Clinical T-TH 8:15am-12:15pm Mar. 31-Apr. 28 Various clinical sites

Class for MockReview 8:15am-12:15am, April 29 Room 220/222

### Application deadline: December 15, 2025

Please note there are two sections include here tor 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. Criticalthinking ability sufficient for clinical judgment.

Example: Identify cause and effect relationship in clinical situations

1. 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.

1. Communicate with others orally and in writing.

Example: Explain procedures, document actions, record client responses to treatment.

1. 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.
2. The ability to manipulate equipment and to assist clients with physical limitations.

Example: Use equipment, calibrate equipment, position clients, administer CPR, and insert catheters.

1. 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.

1. 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.

1. 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 beingable to perform normal weight-bearingactivities. 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 theidentified 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, usinghealthy 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 beutilized 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 satisfactorilycorrected.

**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-casebasis 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.](mailto:twcheek@randolph.edu) and request accommodations.

|  |  |  |
| --- | --- | --- |
| **SKILLS** | **DESCRIPTION** | **SPECIFIC EXAMPLES** |
| **MOTOR SKILLS** | Fine and coarse motor skills | Can stand, bend, tie, open containers, sit, push and pull equipment and furniture, lift from 1Oto 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, 1Oft., 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 |
| CRITICAL **THINKING/ 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. |
| **INTERPERSONAL SKILLS** | 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 usingpersonal 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 licensure, certification exam, or successful completion of the program.*

### ATTENDANCE STUDENTS MUST ATTEND THE FIRST DAY 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 willberequired 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 willnotbeadmitted 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-l pm | Night Classes Meet 5pm-9pm |
| January 21th Tuesday (Kivett) 87980 | January 8th Wednesday (Gaddy) 87981 January 23rd Thursday (King) 87982 |
| February 18thTuesday (Barr) 87986 | February 5th Wednesday (Gaddy) 87985 February 20thThursday- (Benitez) 87987 |
| March 18th Tuesday (Kivett) 87989 | March 5th Wednesday (Gaddy) 87988  March 20th Thursday (King) 87990 |
| April 22nd Tuesday (Barr) 87992 | April 9th Wednesday (Gaddy) 87991  April 24 Thursday- Spanish/English(Benitez) 87993 |
| May 20h Tuesday (Kivett) 87995 | May 7th Wednesday (Gaddy) 87994  May 22thThursday (King) 87996 |
| June 17th Tuesday (Barr) 87998 | June 4th Wednesday (Gaddy) 87997  June 19thThursday- (Benitez) 87999 |
| July 22nd Tuesday (Kivett) 88001 | July 9th Wednesday (Gaddy) 88000  July 24thThursday (King) 88002 |
| August 19thTuesday (Barr) 88004 | August 6th Wednesday (Gaddy) 88003  August 21st Thursday-English/Spanish (Benitez) 88005 |
| September 16th Tuesday (Kivett) 88008 | September 3rd Wednesday (Gaddy) 88006  September 18th Thursday (King) 88009 |
| October 21st Tuesday (Barr) 88011 | October 8th Wednesday (Gaddy) 88010  October 23rd Thursday- (Benitez) 88013 |
| November 18th Tuesday (Kivett) 88014 | November 5th Wednesday (Gaddy) 88012  November 20th Thursday (King) 88015 |
| December 16thTuesday (Barr) 88017 | December 3rd Wednesday (Gaddy) 88016 December 18thThursday-Spanish/English (Benitez)  88018 |
|  |  |

**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 recommended-(provide proof if you have received these)
* Criminal background information form *(signed)*
* Documentation ofreading 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,

Received date: Completion date:

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.

**RANDOLPH**

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### Randolph Community College

**629 Industrial Park Ave., Asheboro NC 27205** / [**www.randolph.edu**](http://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 *I* 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 digitos  □□□□□□□□□ | | | | | |
| E-mail Address/ Correo Electr6nico | | | | | | | | | | | | | |
| Date of Birth/ Fecha de Nacimiento  □□-□□-□□ | | | Employment Status - Circle One/ Estado de empleo - Circule uno  E1 • Employed/ Emp.uao 1-10 Hrs. E4 • Emp oyed 40 or more Hrs. US- Unemp'oyed Seeking/ SuSCJ1ndo empleo E2 • Employed/ Emp!eado 11-20 Hrs. Emp'udo 40 his o mis UN • Unemployed • Nol sae ng  **El•** Employ.,d/Emo.udo 21-3�Hrs. R • Retired/Retirado Oesempleado - Nobus�ndo  Name of Employer/ Nombre de empleador | | | | | | | | | | |
| Ethnic - Circle One / Etnicidad Race - Circle One/ Raza - Circule uno  I. Non-Hispanic/Latino I. American/Alaskan Native 4. Hawaiian/Pacific Island   1. Hispanic/Latino 2. Asian 5. White 2. Black or African American 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) 0 I 2 3 4 *5* 6 7 8 9 10 11 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-Associate's Degree 16-Bachelor's Degree 17-Master's Degree or higher 14- Dioloma Vocacional de un ano 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 Comouters | | | | | **Day(s)**  T Th | | | **Time**  6-9 om | **Fees**  $125 | | | **Location**  Main Campus |
| 1. |  | | | | |  | | |  |  | | |  |
| 2. |  | | | | |  | | |  |  | | |  |

Signature/Firma Date/Fecha Amount Paid/ Cantidad pagada

FoCrERegistration Only/ Solo para registro CE

Method of Payment:  Cash Check Credit Card

Revised 3/29/24 kwt

*Randolph Community College*

(336) 633-0200 [www.randolph.edu](http://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 DMD F MARITAL STATUS □s □MD OTHER EMAIL--------

|  |  |
| --- | --- |
|  |  |
| HOSPITAUHEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) |
| **NAME** OF POLICY HOLDER EMPLOYER  1-c--,---,---,---...,....,,,, ISTHIS AN HMOIPPO/MANAGED CARE PLAN? □YES □NO  POLICY OR CERTIFICATE NUMBER GROUP NUMBER |

**NAME** OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP (MUST NOT BE BOYFRIEND/GIRLFRIENDIFIANCE/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* I | | | | | | | | | | | | | | |
|  | Yes | No | Relationship |  |  | Yes | No | Relationship |  |  | Yes | No | Relationshio |  |
| High blood pressure |  |  |  | Cholesterol or blood fat disorder |  |  |  | Cancer (type): |  |  |  |
| Stroke |  |  |  |
| Heart attack before age  55 |  |  |  | Diabetes |  |  |  | Alcohol/drug problems |  |  |  |
| Glaucoma |  |  |  | Psvchiatric illness |  |  |  |
| Blood or clottina disorder |  |  |  |  |  |  |  | Suicide |  |  |  |
|  |  |  |  |  | |  |  |  | Other (Specify) |  |  |  |

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 |  |  |  |
| �heumatic fever |  |  |  |
| Heart trouble |  |  |  |
| Dain or pressure in r.hest |  |  |  |
| Shortness of breath |  |  |  |
| Asthma |  |  |  |
| Pneumonia |  |  |  |
| Chronic cough |  |  |  |
| Head or neck radiation r,.atm,.nt� |  |  |  |
| umor or cancer  soeciM |  |  |  |
| Malaria |  |  |  |
| Thyroid trouble |  |  |  |
| Diabetes |  |  |  |
| Serious skin disease |  |  |  |
| IAononucleosis |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Hay fever |  |  |  |
| Allergy injection heraov |  |  |  |
| 6-rthritis |  |  |  |
| �oncussion |  |  |  |
| -requent or severe h.,,.,1:,,-he |  |  |  |
| Dizziness or fainting  •~lls |  |  |  |
| Severe head injury |  |  |  |
| Paralysis |  |  |  |
| Disabling depression |  |  |  |
| Excessive worry or anxietv |  |  |  |
| Ulcer (duodenal or  stomach\ |  |  |  |
| ntestinal trouble |  |  |  |
| Pilonidal cyst |  |  |  |
| requent vomiting |  |  |  |
| Gall bladder trouble or aallstones |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Uaundice or hepatitis |  |  |  |
| Rectal disease |  |  |  |
| Severe or recurrent abdominal nain |  |  |  |
| Hernia |  |  |  |
| l:asy fatigability |  |  |  |
| �nemia or Sickle Cell  �nemia |  |  |  |
| l:ye trouble besides need classes |  |  |  |
| Sone, joint, or other   * <>fnrmitv |  |  |  |
| Knee problems |  |  |  |
| �ecurrent back pain |  |  |  |
| **Neck** injury |  |  |  |
| Back injury |  |  |  |
| Broken bone SnPcifv\ |  |  |  |
| Kidney infection |  |  |  |
| Bladder infection |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Kidney stones |  |  |  |
| Protein or blood in  urine |  |  |  |
| Hearing loss |  |  |  |
| Sinusitis |  |  |  |
| Severe menstrual cramos |  |  |  |
| Irregular periods |  |  |  |
| Sexually transmitted |  |  |  |
| Blood transfusion |  |  |  |
| Alcohol use |  |  |  |
| Drug use |  |  |  |
| Anorexia/Bulimia |  |  |  |
| Smoke 1+ pack ciaarett<>�1u,.,.,k |  |  |  |
| Regularty exercise |  |  |  |
| Wear seat belt |  |  |  |
| Other (specify) |  |  |  |

Please list 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 |  |

***FAMILY*** & ***PERSONAL HEALTH HISTORY-CONTINUED*** *(Please print in black ink) To be completed by 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 | Explanation |
| 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 why) |  |  |  |
| Has your academic career been interrupted due to physical or  emotional problems? (Please explain) |  |  |  |
| 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.)

1. 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

***GUIDEUNES FOR COMPLETING IMMUNIZATION RECORD AND 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.)**

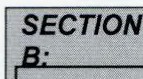
* + High School/Previous College/University Records - These may contain some, but not all of your immunization information. Contact Student Services for help if needed. Your immunization records do not transfer automatically. You must request a copy.
  + Personal Shot Records - Must be verified by a 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)

|  |  |  |
| --- | --- | --- |
| I**IMMUNIZATION REQUIREMENTS ACCORDING TO AGE** | | |
| **STUDENTS17YEARSOFAGEANDYOUNGER**  Tdap Polio Measles2 Every 10 years 3 2 | Mumps4 1 | Rubella4 1 |
| **STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER**  Tdap Polio Measles2•3 Every 1O years 0 2 | Mumps4 1 | Rubella4 1 |
| **STUDENTS BORN BEFORE 1957**  Tdap Polio Measles Every 1O years 0 0 | Mumps 0 | Rubella4 1 |
| **STUDENTS 50 YEARS OF AGE AND OLDER**  Tdap Polio Measles Every 1O years 0 0 | Mumps 0 | Rubella 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 lnduration. 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.

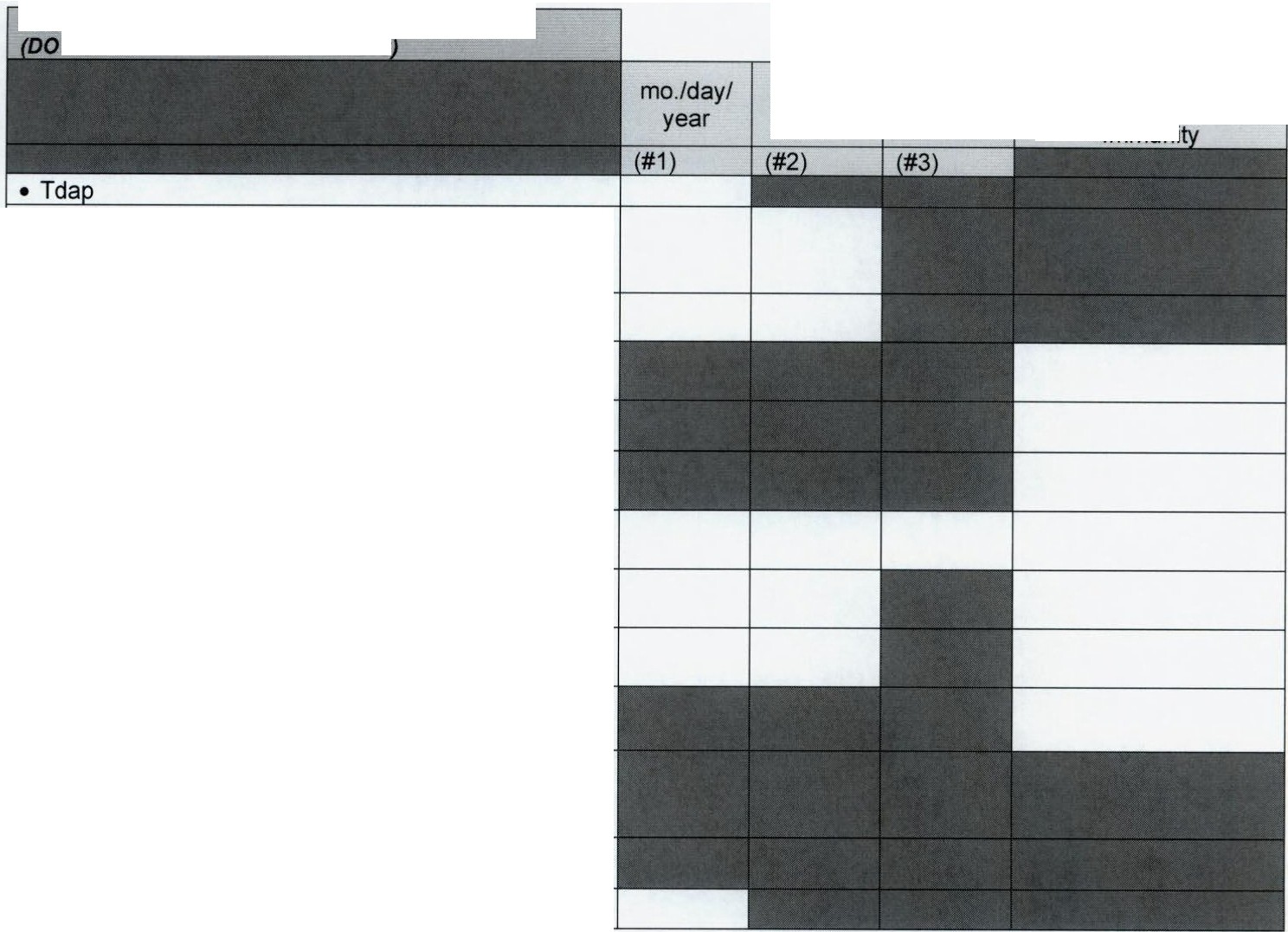


Some may be required by certain departments.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **(Please print** In **black Ink)** To **be completed and signed by physician. A complete**  ***IMMUNIZATION RECORD*** I**Immunization record froma physician should be attached to this form.** | | | | |
| Last Name | First Name | Middle Name I | Date of Birth (mo./day/year) | ILast 4 Digits of Social  Security Number |

|  |
| --- |
| * **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 immunit b ositive blood titer |
| * Varicella (chicken pox) series of two doses or immuni b ositive blood titer |
| * Tuberculin (PPD) Test Date read 1 test 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.



***REQUIRED IMMUNIZATIONS AND TB SCREENING NOT WRITE IN SHADED AREAS***

mo./day/ mo./day/ Titer Date, Numeric year year Result, and Range of

lmmuni

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Menlnaococcak\,.�** .-·- ,,;:,,;,-,.�- ,,r-.;-,,,. '.- \_ \_ Received the men | | inaococcal vaccine? **No** | | **Yes** I |
| If **Yes,** please indicate date(s) vaccine was received (mo./day/year) | |  |  | I |
| ***OPTIONAL IMMUNIZATIONS*** |  | | | |
|  | mo./dav/vear | mo./day/year | mo./day/year | Signatur  e/Clinic Stamp REQUIR  ED: |
| * Haemophilus influenzae type b |  |  |  |
| * Pneumococcal |  |  |  |
| * Heoatitis A series onlv |  |  |  |

Signature of Physician/Physician Assistant/Nurse Practitioner Date

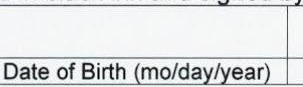
Print Name of Physician/Physician Assistant/Nurse Practitioner Area Code/Phone Number Office Address City State Zip Code

- 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.



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

A h sical examination is re uired. It must be com leted in black ink and si ned b a h sician.



Last Name First Name Middle Name

Last 4 Di its of Social Securi Number

|  |  |
| --- | --- |
|  |  |
| Permanent Address Citv State Zio Code | Area Code/Phone Number |

Height Weight TPR ----�'----'----- BP /

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|  |  |  |  |
| --- | --- | --- | --- |
| ALL SECTIONS REQUIRED: | ALL SECTIONS REQUIRED: |  |  |
| Vision: Corrected Right 20/ \_ Left 20/ | Hearing: (gross) Right \_ | Lett | \_ |
| Uncorrected Right 20/ \_ Left 20/ |  |  |  |
| Color Vision |  |  |  |

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

1. Is there loss or seriously impaired function of any paired organs? Yes \_ Explain

8. Is student under treatment for any medical or emotional condition? Yes \_ Explain

1. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited Explain

No \_

No \_

Limited

1. Is student physically and emotionally healthy? Explain

Yes \_ No \_

Based on my assessment of this student's physical and emotional health on ,he/she appears able to

(Date)

participate in the activities of a health profession in a clinical setting. Yes No if no, please explain \_

* **REQUIRED FOR ALL STUDENTS** •

**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 Regarding Criminal Background Check/Drug Screen for Clinical Externships

Affiliating clinical agencies require a national criminal background check and drug screen as a prerequisite tor clinical learning experiences. Positive results can result in clinical agency

denyingthe student access to clinicalpractice in the facility. Any student who is denied access to any clinical facility will notbeallowed to progress in the pr.ogram\_,\_ 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 willbetheir financial responsibility. DrugScreening- 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 beingrequired. 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 testingmay 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 \_