RANDOLPH COMMUNITY COLLEGE

629 Industrial 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 3240A88285

NA 1- **DAY August 19, 2025- December 3, 2025**

Class T/Wffh 8:15am-12:15pm August 19-October 28
Room 220 Lab T/Wffh 8:15am-12:15pm Room 222
Clinical T/Wffh 8:15am-12:15pm Oct. 29-Dec. 2 Various clinical sites
Class for MockReview 8:15am-12:15am December 3 Room 220/222

Application deadline: July 31, 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

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
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 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. 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-1 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.
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
COLLEGE

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 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.
E2 • Employed/ Emp!eado 11-20 Hrs.
El• Employ.,d/Emo udo 21-3 Hrs.
E4 • Emp oyed 40 or more Hrs. Emp'udo 40 his o mis
R • Retired/Retirado
US- Unemp'oyed Seeking/ SuSCJ1ndo empleo
UN • Unemployed • Nol sae ng Oesempleado - Nobus ndo

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) 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
14- Dioloma Vocacional de un ano
15-Associate's Degree
15-Titulo asociado
16-Bachelor's Degree
16-Licenciatura
17-Master's Degree or higher
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 _____

FOR Registration 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

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––,–––,–––,–––. . . . . I S\$ 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*

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clottina disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationshio
Cancer (type):			
Alcohol/drug problems			
Psvchiatric illness			
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 •~IIs			
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			
:asy fatigability			
nemia or Sickle Cell nemia			
: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.)

(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

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)

IMMUNIZATION REQUIREMENTS ACCORDING TO AGE

STUDENTS17YEARSOFAGEANDYOUNGER

Tdap	Polio	Measles[2]	Mumps[4]	Rubella[4]
Every 10 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 1O years	0	2	1	1

STUDENTS BORN BEFORE 1957

Tdap	Polio	Measles	Mumps	Rubella[4]
Every 1O 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 requirer

IMMUNIZATION RECORD

(Please print in black ink) To be completed and signed by physician. A complete Immunization record from a physician should be attached 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 Range 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 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.

MenInaococcak\,. .-·- ,,;:·,,;,-,. - ,,r-.;-,,,. '.- Received the men inaococcal vaccine? **No** **Yes**

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

OPTIONAL IMMUNIZATIONS

	mo./dav/vear	mo./day/year	mo./day/year
• Haemophilus influenzae type b			
• Pneumococcal			
• Heoatitis A series onlv			

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.

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

Permanent Address	Citv	State	Zio Code	Area Code/Phone Number

Height _____ Weight_____ TPR ____ •____•_____ BP---------- / ___

ALL SECTIONS REQUIRED:	ALL SECTIONS REQUIRED:
Vision: Corrected Right 20/ __ _ Left 20/ Uncorrected Right 20/ ___ _ Left 20/ Color Vision _____	Hearing: (gross) Right _____ __ Lett ____ _

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			

A. Is there loss or seriously impaired function of any paired organs? Yes ___ _ No ___ _
Explain ----------

8. 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 _____ (Date) ,he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain ___ _

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 _____ __