UNIVERSITY OF HAWAI'I • KAPI'OLANI COMMUNITY COLLEGE

Nursing Department Nursing Student Health Checklist – Proof of Clinical Compliance Long-Term Care Nurse Aide Program

Name:				
	Legal LAST	Legal FIRST	Middle initial(s) (if none state "NONE")	
UH ID#: Cell Phone or 1 st Contact No.:				
UH e-mail Address:		@hawaii.edu	Program:	
Instructions: Complete items listed below. Please see the Nurse Aide instructor for details regarding specific facility health requirements.				
For Questions: Email the Nursing Clinical Compliance Coordinator at <u>nurshlth@hawaii.edu</u> for any questions.				
CPR certification:				
Copy of Basic Life Support (BLS) Provider American Heart Association Basic Life Support (CPR and AED) Program. <u>Be sure the</u> <u>vendor you choose is an American Heart Association Authorized Training Center/Trainer</u> . (Note: No exceptions to the above. Certifications received from an online only course will NOT be accepted. Please check the Health Requirements webpage for other restrictions. Adult First Aid/CPR is not acceptable. Must be "BLS Provider Level" by the American Heart Association)				
TUBERCULOSIS (TB) - ONE of the following: Current two-step TB skin test (2 separate injections & 2 readings) with negative results - all indurations must be reported even if the reading				
is negativ	is negative (0mm – 9mm). This is at minimum a 10 day process. OR			
If you've had a positive skin test, provide the date with induration size (i.e. 10mm or more) AND a current (6 months or less from the First day of Course) negative Chest x-ray result . Please be aware that you may be required to submit updated current chest x-ray and waiver form if required by a clinical agency. You must also complete the KCC chest x-ray waiver form.				
Measles, Mumps, and Rubella (MMR) Immunity:				
Documentation of two (2) MMR Vaccines OR Copy of positive titer (blood test) results for <i>all</i> of the following: Measles, Mumps and Rubella as proof of immunity.				
VARICELLA (Chicken pox) Immunity:				
Documentation of two (2) Varicella Vaccines OR Copy of a positive Varicella (chicken pox) titer (blood test).				
HEPATITIS B Immunity:				
Documentation of (3) Hepatitis B Vaccines OR Copy of positive Hepatitis B Surface Antibody titer blood test (HbsAb).				
ANNUAL SEASONAL INFLUENZA VACCINATION:				
Documentation of flu vaccination within the current seasonal period (A new vaccine arrives every August until May).				
INFLUENZA VACCINE Attestation/Declaration Forms:				
KCC Influenza Vaccination Attestation/Declaration Form - Signed and dated. The only reason to decline the flu vaccine				
must be substantiated by a medical note from your primary care provider.				
1	EXAMINATION FORM:		ompleted within 6 months to start of program)	
Form to be completed by healthcare provider verifying ability to perform program activities.				
MEDICAL CONSENT FORM:				
Signed and dated				
UNDERSTANDING AND AGREEMENT FORM:				
Signed and dated				
EXCLUSION OF WORKERS' COMPENSATION/ CONFIRMATION OF HEALTH INSURANCE COVERAGE FORM:				
Signed and dated				
Valid personal MEDICAL Insurance Card (Front and Back) copy to be uploaded.				
DOCUMENT RELEASE FORM: Signed and dated				
Signed a	ina dated			