Nursing Assistant – Home Health Aide
Susan Hill, RN
School Year 2014-2015
M (863) 224-3727

Course Description and Objectives
This course is the third in a series of courses in the Medical Academy. This course is one of three to complete the Gold Seal Vocational Program in Health Occupations. The course is two semesters and upon successful completion of this course the student may receive 1.5 elective credits towards Bartow Senior High School (BHS) graduation requirements. The primary purpose of the course is to prepare the student entering the health care profession. Upon successful completion of the class room, clinical training and community service hour requirements, the students receive a Home Health Aide Certificate and will be eligible to take the state exam for Certified Nursing Assistants. Upon passing this state exam, the student will receive his/her certificate for Certified Nursing Assistant issued by the State of Florida.

Rules and Regulations

Mandatory Requirements

1. Complete Course and Pass Exam for Basic Cardiac Life Support
2. Complete Course and Pass Exam for HIV/AIDS/Medication Errors
3. Complete successfully 40 hours of Clinical Training
4. Complete 32 hours of Community Service to the Elderly
5. Complete all required lab skill requirements as listed
6. Complete all classwork requirements as listed
7. Maintain 2.5 GPA
8. Complete and Pass CPE Exams

Grading Scale

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<tr>
<th>Grade</th>
<th>Percentage</th>
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<td>92 – 100 = A</td>
<td>20%</td>
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<td>85 – 91.9 = B</td>
<td>10%</td>
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<td>80 – 84.9 = C</td>
<td>10%</td>
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<td>70 – 79.9 = D</td>
<td>10%</td>
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<td>Below 70 = F</td>
<td>20%</td>
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State Certified Nursing Assistant Exam Fee:

Each student must pay $70.00 toward the cost of the state exam, due by February 1, 2015
**Student/Parent Initials Required for Each Section**

_____/_____ Clinical Training
The Nursing Assistant Program includes clinical training. The student is required to participate in the clinical training program. Dates and times of clinical training will be assigned by the program instructor. When in the clinical setting, the student shall be properly dressed, on time, act professionally (“professional” is at the discretion of the instructor and/or the supervisor of the clinical training site) and have all appropriate material and supplies. Otherwise, the student may be removed from the clinical training site and be unable to complete the course. The Bartow Senior High School Code of Conduct also applies when assigned to clinical training. All students in the clinical training program **must maintain a 2.5 GPA average in class to participate in clinical training.** You will be dropped from The Nursing Assistant – Home Health Aide Program if your GPA falls below a 2.5 average.

_____/_____ Immunizations
_____ Hepatitis B or declination waiver
_____ Hepatitis C titer
_____ MMR
_____ Tdap
_____ PPD (tuberculin skin test)
_____ Varicella
_____ Flu Vaccine

Due to the potential communicable disease exposure, the student must have all immunization up to date. A **TB skin test** (PPD) will also be required per clinical site requirements. **Proof** of all immunizations must be on file with the instructor before you may participate in the clinical training portion of the program. A current physical (valid through May 2015) must also be on file prior to the clinical training portion of the program. **Deadline:** end of first 9-week grading period.

_____/_____ Drug Testing/Background Check
It is the policy of BHS Medical and Public Safety Academy (MAPS) to maintain a student body free from the use of illegal drugs and be of good moral character. The Department of Health requires a livescan background check scheduled through the Morphotrust Website. The cost of this background check is approximately $76.50 and must be paid with a credit card or debit card at the time of registration. Also, a 10-panel drug screening, with an approximate cost of $18.00, prior to beginning clinical training **AND** under the following circumstances:

1. Pre-Clinical: Test results must be on file with the facility prior to the student’s entry into the clinical training area.

2
2. Reasonable Suspicion: When there is reasonable suspicion (“reasonable suspicion” is at the discretion of the instructor and/or supervisor of the clinical training site) to believe that a student is using or has used illegal drugs. Examples are as follows:
   a. Observable incident at school or clinical training site such as direct observation of drug use or the physical symptoms or manifestations of being under the influence of a drug;
   b. Abnormal conduct or erratic behavior while at school or clinical training site or a significant deterioration in school or nursing assistant performance;
   c. A report of drug use, provided by a reliable and credible source;
   d. Evidence that an individual has tampered with a drug test during his/her pre-clinical testing;
   e. Information that a student has caused, contributed to, or been involved in an accident while at the clinical training site; or
   f. Evidence that a student has used, possessed, sold, solicited, or transferred drugs while at school or while at clinicals.

10-panel drug screen may include but not be limited to the following:

1. Cannabinoids
2. Cocaine
3. Amphetamines (amphetamine, methamphetamine)
4. Opiates (heroin, opium, codeine, morphine, 6-MAM)
5. Phencyclidine (PCP)
6. Methadone
7. Barbiturates
8. Benzodiazepines
9. Tricyclic antidepressants
10. Methylenedioxymethamphetamine (MDMA or ecstasy)

Cost of the drug testing and background check will be the responsibility of the student. Approximately ($94.50)

_____ / ____ Attendance
The student should be present to all classes and clinical training assignments. In the case of missed class time, work may be made up according to the Polk County School Board policy. It is the student’s responsibility to contact the program instructor when absent. **If you miss school on a clinical training day, you cannot report to your clinical site.** It will be the student’s responsibility to make up any missed clinical training assignment, **if that option is available.** You must remember, schedules for clinical training are coordinated with many individuals and clinical training sites. Therefore, make-up of a clinical training assignment may not be possible.
Tardy
I expect all students to be on time and in their appropriate seats when the tardy bell rings. If the student is late for clinical training, we treat it the same as being late for a job. Follow the policies and procedures for the clinical training site and immediately contact the clinical instructor, prior to the time to report.

Disciplinary actions
Parent or guardian contact is an option open to the instructor at any time. If possible, the instructor will have a student/teacher discussion before involving parents/guardians. If a solution cannot be agreed to, parents/guardians will be involved. If the infraction is severe enough (“severe enough” is at the discretion of the instructor and/or supervisor at the clinical training site), school administration will be involved and you may be dropped from the Nursing Assistant – Home Health Aide Program. If you are dropped from the program, you will not be allowed to take your state exam for Certified Nursing Assistant through Bartow Senior High School Nursing Assistant Program.

Evaluation
Written unit tests may be given at the completion of each unit. These tests may include questions from the textbook, homework and material covered during class time. In addition, Clinical Practice Exams (CPE’s) will be administered throughout the program. The CPE will be a practical (hands-on) exam of clinical skills taught in the nursing assistant lab. Each CPE will consist of two to three random skills. The student must pass all CPE’s in order to attend clinical training. If the student fails a CPE, the student will have the option of retaking the CPE to include the skill(s) failed and two additional skills. If the student fails the second attempt, the student will not be allowed to attend clinical training and will be unable to complete the program. The student will not be allowed to take the state exam for Certified Nursing Assistant through Bartow Senior High School Nursing Assistant Program.

Homework and Assignments
Students will be given homework and out of class assignments. These assignments shall be turned in at the assigned time. All work must be submitted in a professional manner.

Class Material
Binder – 2 inch, Dividers, Notebook paper, Pen- black ink, Flash drive
_____ / _____ Skills Lab
Many skills will be taught in the nursing assistant lab during the first semester to prepare the student for clinical training. Each student must be checked off on each skill and pass **Clinical Practice Exams (CPE’s)** testing prior to attending the clinical training. The skills will be demonstrated by the instructor. After the demonstration, the student will practice the skill until proficient. The student may then request to be tested for competency on the skill. If proficient, the instructor will sign and date the skill sheet. If unsuccessful, the student will be required to practice and then be tested again for competency. Additional assistance is available. See your instructor for times. It is the student’s responsibility to keep the skill sheets in the student binder. If the skill sheet is missing or not signed, the student will not be given credit for completing that skill and will not be able to report to the clinical training site.

_____ / _____ Clinical Training Required Documentation
**Required** prior to Clinical Training
- Medical Examination (physical) no more than a year old, valid through May 2015, with current immunization record
- PPD (check with your instructor for date required)
- Medical Treatment Authorization Form
- Blanket Field Trip Permission Form
- Rules/regulation and Policies form-signed
- Copy of Drivers License
- Copy of Social Security Card
- Copy of CPR Card
- Discussion with parent/guardian
- Drug testing results – per facilities request
- Background check – per facilities request
- STW training agreement
- Affidavit of Good Moral Character

_____ / _____ Clinical Training Uniform Policy
**Purpose**
1. Identifies you to the public and hospital staff as a student
2. Presents a professional appearance
3. Prevents possible cross contamination by separating street clothes from work clothes.

- Scrubs – Royal Blue with BHS Medical Academy Logo
- White or black athletic or nursing shoes
- White or black socks (must match shoe color)
- Watch with second hand
- Name Badge
- Pen – Black Ink
Uniforms must be worn to all clinical training. The uniform policy will be strictly enforced. Failure to appear in uniform will result in dismissal from the clinical training site and an absence recorded. Head coverings of any kind are not allowed. Jackets and sweaters are not to be worn in the clinical training site. During cold weather, the student may wear a white or black long sleeved shirt (must match shoe color) under the scrub top or a matching royal blue scrub jacket. A variety of uniform styles are available. Students may choose their own uniform vendor.

Classroom Uniform policy
- Scrubs – Royal Blue or
- BDU’s – Navy Blue and Royal Blue Polo with BHS Medical/Public Service Academy Logo. Navy Blue Dickies will also be accepted.
- Close Toed Shoes

Uniforms must be worn to all program functions unless otherwise informed. The uniform must be worn to class every day the student has a MAPS Academy class. The uniform code will be strictly enforced. Head coverings of any kind are not allowed. A variety of uniform styles are available. Students may choose their own uniform vendor.

Clinical Training Hygiene, Hair, Jewelry, Fingernails, Tattoos, Piercings
While at the clinical training site, students must be well groomed and hair must be above the collar. Long hair must be neatly clipped to the back of the head with a neutral colored clip. Extreme or distracting (“extreme or distracting” is at the discretion of the instructor) hair styles or color will not be allowed. Uniforms will be neat and free of wrinkles. Shoes will be clean and polished. Shoe laces will be tied securely and socks must be worn. Make-up will be at a minimum. Perfume, cologne, fragranced lotions, etc. are NOT to be worn. One set of stud type earrings may be worn. One ring per hand is allowed. No artificial fingernails of any kind will be allowed. You must keep your fingernails clean and no longer than the end of your finger. Fingernails may be painted a pale neutral color or clear. Tattoos may not be visible. Visible body piercing jewelry, other than ears, (including oral piercings) is not allowed.

Clinical Training and Community Service
20 hours – Extended Care Facility
20 hours – Acute Care Facility
32 hours of community service to the elderly – Home Health Aide

Clinical Training Policies and Procedures
- When in the clinical setting, the student shall be properly dressed, on time, act professionally (“professional” at the discretion of the instructor and/or supervisor of the clinical training site) and have all appropriate material and supplies.
- The nursing assistant student will remain in uniform at all times.
- Any food/beverage in the patient care area is prohibited.
- Students will not appear for clinical session under the influence of alcohol or other substances. (a violation will result in immediate dismissal from program).
- Any injury received during clinical training shall be reported to the instructor immediately.
During clinical training, students may use cell phones only to contact the instructor. Cell phones shall be visible in the break room or bathroom only. Personal calls are to be made during break time only and in the break room only. Cell phones are to be on silent or vibrate. Any violation of the above may result in removal from the program and if removed, you will not be allowed to take the state exam for Certified Nursing Assistant through Bartow Senior High School Nursing Assistant Program.

Clinical Training Documentation Requirements

The BHS nursing assistant program must be able to verify that students have met certain educational standards for completion of the course. Therefore, the following documentation is required:

Clinical Training Evaluation Reports

These form(s) are to be completed by the preceptor each clinical day. These form(s) will be turned in to the instructor by the student at the end of each clinical training day during post clinical conference. Once graded, the evaluation form will be returned to the student to be placed in the student’s binder. It is the responsibility of the Nursing Assistant student to complete and submit all forms and reports.

Removal of Student from Clinical Training Site

The student may be removed from the clinical training site at any time if, at the discretion of the instructor and/or supervisor of the clinical training site, the actions of the student may in any way compromise patient care, compromise the relationship between the school and clinical training site or contribute to an unsafe environment. A student withdrawn from the clinical training may pursue grievance procedures. However, the student may not return to the clinical areas during the interim and will not receive credit for the clinical. The following persons may ask the student to leave the clinical training site.

- Nursing Assistant – Home Health Aide Instructor
- Facility administrator (or designee).
Bartow Senior High School Medical/Public Service Academy Core Values and Expected Behaviors:

At BHS, we teach students to provide the best healthcare possible. We achieve this through having a foundation of solid values and expected behaviors.

CARE "I thoughtfully serve the needs of others."
- I provide for the physical, emotional, and spiritual needs of my patients and their families.
- I lend a helping hand.
- I actively listen.
- I seek and value different ideas.

STEWARDSHIP "I effectively use resources to best serve the health care needs of the community."
- I take care of school/hospital property and equipment.
- I use my time, talents, and supplies wisely.
- I am an ambassador of BHS in and out of clinical training.
- I volunteer to serve others and the community.

INTEGRITY "I am sincere in doing the right thing."
- I am honest.
- I am fair.
- I am forgiving.
- I am trusting.

QUALITY "I pursue the highest standards of care and safety."
- I study and practice skills.
- I change to improve quality and service.
- I keep everyone safe.
- I exceed the expectations of my teachers and patients.
ACCOUNTABILITY "I have unwavering commitment to my performance and I am responsible for my own actions."
  - I know and do what is expected.
  - I ask for what I need.
  - I work well with and think of others before I act.
  - I balance my life in and out of school.

COURTESY "I am kind and polite in all interactions."
  - I always introduce myself.
  - I say "please" and "thank you."
  - I use respectful language and communication.
  - I treat others with dignity and respect

Acknowledgement
This syllabus has been created as a guide. However, all information is subject to change as needed. Any changes will be announced in class. An attempt has been made to cover the major aspects of the course and the expectations of the student.
Bartow Medical and Fire Academy

NAME: ________________________________________ _______ Period______________________

FOR PROGRAM OFFICE USE ONLY

1. ______ STUDENT INFORMATION
2. ______ FREE FROM ADDICTION, MENTAL, OR PHYSICAL DISEASE OR DEFFECT
3. ______ COPY OF DRIVERS LICENSE, CPR CARD & SS CARD
4. ______ COMPLIANCE AGREEMENT
5. ______ SIGN AND PROVIDE COPY OF INSURANCE
6. ______ PHYSICAL EXAM
7. ______ IMMUNIZATION SCHEDULE
8. ______ AFFIDAVIT OF GOOD MORAL CHARACTER
9. ______ PCSB MEDICAL TREATMENT AUTHORIZATION FORM
10.______ PCSB BLANKET FIELD TRIP FORM
11.______ 10 PANEL DRUG SCREEN BACKGROUND CHECK PERMISSION FORM AND RESULTS
Bartow Medical and Fire Academy

STUDENT INFORMATION

PLEASE PRINT

NAME: (LAST)________________________ (FIRST) ___________________

ADDRESS: __________________________________________________________

CITY: ______________________ STATE: _______ ZIP CODE: _______________

HOME PHONE: ___________________ CELL# ____________________________

SOCIAL SECURITY # ______ - _____ - _____ SEX: M  F  AGE: _____________

EMAIL: _____________________________________________________________

PARENTS NAME: _____________________________________________________

ADDRESS: __________________________________________________________

CITY: ______________________ STATE: _______ ZIP CODE: _______________

EMAIL: _____________________________________________________________

HOME PHONE: ____________________________

CELL PHONE: ____________________________

Other activates you are involved in such as football, band, etc.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
STATEMENT OF FREEDOM FROM ADDICTION OF DRUGS, MENTAL OR PHYSICAL DISEASE AND/OR DEFECT THAT MAY IMPAIR MY ABILITY TO PERFORM AS A NURSING ASSISTANT STUDENT. I UNDERSTAND THAT AT ANY TIME MY INSTRUCTORS AND OR PRECEPTORS MAY ASK ME TO TAKE A RANDOM DRUG TEST. I FURTHER UNDERSTAND I AM REQUIRED TO SUBMIT TO A 10 PANEL DRUG SCREENING AND LEVEL II BACKGROUND CHECK SET UP BY MY INSTRUCTOR THROUGH THE POLK COUNTY SCHOOLBOARD AND MAY BE RESPONSIBLE FOR THE COST.

I, ____________________________ HEREBY SWEAR THAT:

PRINT

A) I AM FREE FROM ADDICTION TO ALCOHOL AND/OR ANY CONTROLLED SUBSTANCE.

B) I AM FREE FROM ANY PHYSICAL AND/OR MENTAL DEFECT OR DISEASE THAT MIGHT IMPAIR MY ABILITY TO PERFORM AS A NURSING ASSISTANT STUDENT.

_______________________________________
APPLICANT SIGNATURE                  DATE

Personally known or type of identification and number: ____________________________________________

Sworn to and subscribed before me this ______ day of ___________________________ 20____

_______________________________________
NOTARY SIGNATURE/SEAL                      DATE

_______________________________________
PARENT/GUARDIAN SIGNATURE                  DATE

Personally known or type of identification and number: ____________________________________________

Sworn to and subscribed before me this ______ day of ___________________________ 20____

_______________________________________
NOTARY SIGNATURE/SEAL                      DATE
ATTACH A COPY OF YOUR DRIVERS LICENSE OR FLORIDA I.D. CARD HERE:

COPY OF SOCIAL SECURITY CARD HERE:

COPY OF CPR CARD HERE:
Bartow Medical and Fire Academy

COMPLIANCE AGREEMENT: THIS AGREEMENT IS REQUIRED TO INSURE THAT ALL STUDENTS HAVE BEEN INFORMED OF CERTAIN RIGHTS THE STUDENT IS ENTITLED TO, ACCORDING TO STANDARD POLK COUNTY SCHOOL BOARD POLICY.

I _____________________________, HEREBY SWEAR THAT:

I HAVE READ THE SYLLABUS/OBJECTIVES MANUAL AND HAVE OBTAINED A CURRENT STUDENT HANDBOOK AND HAVE READ ALL SECTIONS, INCLUDING BUT NOT LIMITED TO: STUDENTS RIGHTS AND RESPONSIBILITIES DUE PROCESS HEALTH SERVICES CLASS ATTENDANCE AND ABSENCES STUDENT CONDUCT DISCIPLINE, AND DUE PROCESS. I UNDERSTAND AND AGREE TO COMPLY WITH THE POLICIES, RULES, AND REGULATIONS IN BOTH PUBLICATIONS. I FURTHER UNDERSTAND THAT IF I FAIL TO MEET THE REQUIREMENTS OF THE BARTOW SENIOR HIGH SCHOOL MEDICAL AND FIRE ACADEMY NURSING ASSISTANT PROGRAM, I WILL BE DENIED CREDIT FOR THE CLASS AND AN “F” WILL BE ENTERED ON MY HIGH SCHOOL TRANSCRIPT.

________________________________________  ____________________________
APPLICANT SIGNATURE                      DATE

Personally known or type of identification and number:_____________________________________

Sworn to and subscribed before me this _______ day of __________________________20_____

________________________________________  ____________________________
NOTARY SIGNATURE / SEAL                    DATE

________________________________________  ____________________________
PARENT/GUARDIAN SIGNATURE                  DATE

Personally known or type of identification and number: ________________________________

Sworn to and subscribed before me this _______ day of __________________________20_____
Bartow Medical and Fire Academy

VERIFICATION OF STUDENT HEALTH INSURANCE. PLEASE ATTACH A COPY OF YOUR CURRENT HEALTH INSURANCE OR A COPY OF THE COMPLETED APPLICATION FOR STUDENT HEALTH INSURANCE. THIS IS REQUIRED FOR ALL STUDENTS ENROLLED IN THE NURSING ASSISTANT PROGRAM. THE SCHOOL BOARD IS NOT RESPONSIBLE FOR ANY ACCIDENTS OR INJURIES WHICH MAY OCCUR IN THE TRAINING PROGRAM.

I ___________________________ (PARENT/GUARDIAN)

PRINT

UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE TREATMENT OF ANY ACCIDENT OR ILLNESS WHICH MAY OCCUR WHILE MY CHILD IS ENGAGED IN ANY PROGRAM ACTIVITY.

______ I HAVE A CURRENT HEALTH INSURANCE POLICY WITH ____________________________

I AGREE TO MAINTAIN THIS POLICY DURING THE PROGRAM. INSURANCE COMPANY

______ I DO NOT HAVE A CURRENT HEALTH INSURANCE POLICY. I UNDERSTAND THAT I WILL BE COVERED BY POLK SCHOOLBOARD INSURANCE POLICY THAT WILL COVER ME WHILE I AM AT MY CLINICAL ONLY.

______________________________ APPLICANT SIGNATURE DATE

Personally known or type of identification and number: ______________________________________

Sworn to and subscribed before me this _____ day of ___________________________ 20____

______________________________ NOTARY SIGNATURE / SEAL DATE

______________________________ PARENT/GUARDIAN SIGNATURE DATE

Personally known or type of identification and number: ______________________________________

Sworn to and subscribed before me this _____ day of ___________________________ 20____

______________________________ NOTARY SIGNATURE/SEAL DATE
ATTACH PROOF OF INSURANCE HERE

Bartow Medical and Fire Academy
PRE-ENTRANCE PHYSICAL EXAMINATION

THE MEDICAL EXAMINER IS REQUIRED TO MAKE A CAREFUL PHYSICAL EXAMINATION. IMPAIRMENTS FOUND AFTER ADMISSION MAY LEAD TO THE REJECTION OF THE APPLICANT DUE TO THE INABILITY OF THE APPLICANT TO MEET PATIENT CARE RESPONSIBILITIES.

THIS FORM MUST BE COMPLETED AND RETURNED
ACCORDING TO FLORIDA LAW, GENERAL AUTHORITY SECTION 15, CHAPTER 73-125: AN APPLICANT MUST BE FREE FROM ANY PHYSICAL OR MEDICAL DEFECT OR DISEASE WHICH MIGHT IMPAIR THE APPLICANTS ABILITY TO ATTEND CLINICAL TRAINING.

NAME: ___________________________ DATE: ____________

DATE OF BIRTH: _____ / _____ / ______

HEIGHT: _______________ WEIGHT: ___________ LBS. TEMPERATURE: _________

BLOOD PRESSURE: _____ / ______ PULSE: _________ RESPIRATION: ________

(WITHOUT CORRECTIVE LENSES) (WITH CORRECTIVE LENSES)

Distance Vision: Right: _____ Left: _____ Both: ______
Near Vision: Right: _____ Left: _____ Both: ______
Color Vision: Right: _____ Left: _____
Hearing: Right: _____ Left: ______

LIST ANY MAJOR ILLNESSES, OPERATIONS, AND HOSPITALIZATIONS (INCLUDE DATES):

__________________________________________________________

CURRENT MEDICATIONS: ______________________________________

ALLERGIES: ________________________________________________

FAMILY HISTORY: ___________________________________________

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<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Notes / Comments</th>
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<td>General Appearance</td>
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<td>Nose, and Sinuses</td>
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<td>Mouth and Throat</td>
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<td>Teeth and Gums</td>
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<td>Ears (In General) and Ear Drums</td>
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<td>Lungs</td>
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<td>Heart</td>
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<td>Upper Extremities</td>
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<td>Back and Spine</td>
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<td>Skin</td>
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<tr>
<td>Neurological Examination, Including Reflexes</td>
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Other abnormalities or explanation of above findings: __________________________________________________________
__________________________________________________________________________________________________

**RECOMMENDATIONS:**

_I HAVE THIS DAY GIVEN_________________________________________ A CAREFUL EXAMINATION AND FOUND HIM / HER TO BE IN__________________________ HEALTH._

_AFTER THIS EXAMINATION, DO YOU BELIEVE THAT THIS APPLICANTS HEALTH HISTORY AND PHYSICAL FINDINGS JUSTIFY HIM / HER TO UNDERTAKE THE CLINICAL RESPONSIBILITIES OF THE PROGRAMS AT BARTOW SENIOR MEDICAL ACADEMY?_  

YES _____ No_______

_PLEASE TYPE, PRINT OR STAMP THE NAME OF MEDICAL EXAMINER AND ADDRESS_  

Signature of Physician: ___________________________ Date: __________
Bartow Medical and Fire Academy

IMMUNIZATION SCHEDULE

T-DAP WITHIN THE LAST 10 YEARS
DATE GIVEN: ___________________________
BY: ___________________________________
SIGNATURE: ___________________________
NAME / TITLE OF AGENCY: (Print or Stamp)

MEASLES, MUMPS, AND RUBELLA (MMR) or Laboratory evidence of rubella / rubella immunity.
DATE GIVEN: ___________________________
BY: ___________________________________
SIGNATURE: ___________________________
NAME / TITLE OF AGENCY: (Print or Stamp)

VARICELLA (Chicken Pox) Titer (Titer is required)
DATE GIVEN: ___________________________
BY: ___________________________________
SIGNATURE: ___________________________
REPORT: POSITIVE _____ NEGATIVE _____
NAME / TITLE OF AGENCY: (Print or Stamp)

FLU VACCINE (Required prior to January 2015)
DATE GIVEN: ___________________________
BY: ___________________________________
SIGNATURE: ___________________________
NAME / TITLE OF AGENCY: (Print or Stamp)

PPD WITHIN THE PAST THREE (3) MONTHS. APPLICANTS WITH POSITIVE RESULTS MUST HAVE A CHEST X-RAY. APPLICANTS WITH A NEGATIVE RESULT DO NOT REQUIRE A CHEST X-RAY.
DATE GIVEN: ___________________________
BY: ___________________________________
SIGNATURE: ___________________________
NAME / TITLE OF AGENCY: (Print or Stamp)
DATE OF CHEST X-RAY: ___________________
REPORT: POSITIVE _____ NEGATIVE _____
BY: ___________________________________
SIGNATURE: ___________________________
ASSESSED BY: __________________________
SIGNATURE: ___________________________
HEPATITIS C Antibody Testing within past six (6) months of clinical start date:

DATE GIVEN: __________________________ NAME / TITLE OF AGENCY: (Print or Stamp)
BY: _________________________________
SIGNATURE: __________________________
PROVIDE COPY OF REPORT: POSITIVE ____ NEGATIVE ____

HEPATITIS B SERIES. IF THE APPLICANT CHOOSES NOT TO RECEIVE THIS IMMUNIZATION, THE WAIVER AT THE BOTTOM OF THIS FORM MUST BE SIGNED.

DATE GIVEN: __________________________ NAME / TITLE OF AGENCY: (Print or Stamp)
BY: _________________________________
SIGNATURE: __________________________

DATE GIVEN: __________________________ NAME / TITLE OF AGENCY: (Print or Stamp)
BY: _________________________________
SIGNATURE: __________________________

DATE GIVEN: __________________________ NAME / TITLE OF AGENCY: (Print or Stamp)
BY: _________________________________
SIGNATURE: __________________________

Date: __________________

Rejection of Immunization
This will certify that I, the undersigned, understand the risk of exposure and possible complications which may occur as a result of contact with patients who have Hepatitis B.

Should I contract Hepatitis while at the clinical training site as a student, I will not hold the Hospital, Nursing Home, Bartow Senior High School Medical and Fire Academy or the Polk County School Board or any of the representatives responsible.

Signature: ___________________________ Date: __________________

THIS MAY BE OBTAINED FROM THE POLK COUNTY SCHOOL BOARD FILE BY THE STUDENT.
THE STUDENT WILL STILL NEED TO OBTAIN A CURRENT TB TEST FOR THIS SCHOOL YEAR.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>1. TDAP</strong></td>
<td>TDaP: Tetanus, Diphtheria, and Pertussis; to get tetanus with pertussis, it has to have been at least 2 years since last tetanus.</td>
</tr>
<tr>
<td><strong>2. MMR</strong></td>
<td>If born after 1957, verification of MMR immunity via documentation of immunization series, physician documentation of disease, or titer</td>
</tr>
<tr>
<td><strong>3. Varicella</strong></td>
<td>Verification of varicella immunity via documentation of immunization series, physician documentation of varicella or shingles, or titer</td>
</tr>
<tr>
<td><strong>4. PPD</strong></td>
<td>PPD within 3 months (Dec. 2015) of initial clinical assignment, as required by LRMC/BFD/PCEMS; chest X-ray if positive PPD; physician documentation of status if CXR positive</td>
</tr>
<tr>
<td><strong>5. Hepatitis C</strong></td>
<td>Hepatitis C titer no more than one year old</td>
</tr>
<tr>
<td><strong>6. Hepatitis B</strong></td>
<td>Hepatitis B series and titer or signed declination waiver</td>
</tr>
<tr>
<td><strong>7. Background check</strong></td>
<td>Required by LRMC/BFD/PCEMS Students will have this done by law enforcement and results given to instructor for file</td>
</tr>
<tr>
<td><strong>8. 10 panel Drug screen</strong></td>
<td>Required by LRMC/BFD/PCEMS Students will have this done by a lab of their choosing and results faxed to instructor for file</td>
</tr>
<tr>
<td><strong>9. Flu Vaccine</strong></td>
<td>Required prior to January 2015</td>
</tr>
</tbody>
</table>
State of Florida County of Polk
BEFORE ME this day personally appeared __________________________________________
Who, being duly sworn, deposes and says:

I hereby attest that I am of good moral character, that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

(1) Section 415.111 relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
(2) Section 782.04 relating to murder
(3) Section 782.07 relating to manslaughter
(4) Section 782.071 relating to vehicle homicide
(5) Section 782.09 relating to killing an unborn child by injury to the mother
(6) Section 784.011 relating to assault, if the victim of the offense was a minor
(7) Section 784.021 relating to aggravated assault
(8) Section 784.03 relating to battery, if the victim of the offense was a minor
(9) Section 784.045 relating to aggravated battery
(10) Section 787.01 relating to kidnapping
(11) Section 787.02 relating to false imprisonment
(12) Section 794.011 relating to sexual battery
(13) Chapter 796 relating to prostitution
(14) Section 798.02 relating to lewd and lascivious behavior
(15) Chapter 800 relating to lewdness and indecent exposure
(16) Section 806.01 relating to arson
(17) Chapter 812 relating to theft, robbery, and related crimes, if the offense is a felony. (See 812.014, 812.016, 812.019, 812.081, 812.13, 812.133, 812.135, 812.14, 812.16)
(18) Section 817.563 relating to fraudulent sale of controlled substances, only if the offense was a felony
CNA Syllabus 2014-2015

(19) Section 826.04 relating to incest

(20) Section 827.03 relating to aggravated child abuse

(20) Section 827.05 relating to negligent treatment of children

(21) Section 827.071 relating to sexual performance by a child

(22) Chapter 847 relating to obscene literature

(23) Chapter 893 relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

I further attest that I have not been judicially determined to have committed abuse or neglect against a child as defined in s.3901(2) and (36), Florida Statutes; nor do I have a confirmed report of abuse, neglect, or exploitation as defined in s.415.102, or abuse or neglect as defined in s.415.503 (3), which has been uncontested or upheld under s.415.103 or s.415.504, Florida Statutes; nor have I committed an act which constitutes domestic violence as defined in s.741.28, Florida Statutes.

Under the penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

_______________________________________
Affiant

OR

To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts or offenses.

_______________________________________
Affiant

SWORN TO AND SUBSCRIBED before me this ______ day of _________________________, 20___,
By ________________________________, who is personally known to me or has produced ________________________________, as identification, and who did take an oath.

______________________________
Signature of Notary Public - State of Florida

______________________________
Print, Type or Stamp Name of Notary Public

22
THE SCHOOL BOARD OF POLK COUNTY
MEDICAL TREATMENT AUTHORIZATION FORM

TO WHOM IT MAY CONCERN:

I the undersigned parent/guardian of ________________________________________ hereby authorize any necessary medical treatment for this student while participating in field trips conducted under the sponsorship of Bartow Medical & Fire Academy & ALL HOSA Events during the 2014-2015 school year and guarantee payment of all charges incurred as a result of this medical treatment.

INFORMATION: Please Print

ALLERGIES TO FOOD, MEDICATION, ETC. (If none, so state.) __________________________

SPECIAL MEDICAL CONDITIONS (If none, so state.) ______________________________________

FAMILY PHYSICIAN ________________________________________________________________

OFFICE ADDRESS ______________________________ PHONE NO________________________

PARENT/GUARDIAN NAME ____________________________________________________________

PARENT/GUARDIAN HOME ADDRESS __________________________________________________

HOME PHONE___________________________ WORK PHONE_______________________________

Insurance Company, Policy No. or Group No. ____________________________________________

PARENT/GUARDIAN SIGNATURE __________________________ DATE ________________

STATE OF FLORIDA, COUNTY OF ______________________________

I hereby certify that the foregoing was executed before me this ___day of ____________ 20___

by ________________________________, who is personally known to me or who has produced ________________________________as identification and who did (did not) take an oath.

____________________________________
Notary Public, State of Florida

THIS FORM IS TO BE USED FOR ALL OUT-OF-COUNTY FIELD TRIPS EXCEPT ATHLETIC ACTIVITIES. THE FORM SHOULD BE COMPLETED PRIOR TO THE STUDENT’S FIRST OUT-OF-COUNTY TRIP AND RETAINED ON FILE FOR THE REMAINDER OF THE SCHOOL YEAR.
THE SCHOOL BOARD OF POLK COUNTY 
BLANKET FIELD TRIP PERMISSION FORM

TO WHOM IT MAY CONCERN:

_____________________________ has my permission to participate in all
Name of student

Field trips to be taken by Bartow Senior High Medical Academy and HOSA Events_____
Name of organization/group

During the __2014 - 2015__ school year. As parent/guardian I acknowledge the following:

1. School officials are authorized to obtain emergency medical treatment for this student as necessary.

2. The School Board has made available to this student the opportunity to purchase student accident insurance.

3. During this field trip, that the School Board will not be liable for injury to this student as result of the negligence, errors, and omissions of others (i.e., charter bus owners and drivers, or amusement park owners or workers), their agents, heirs, employees or assigns either through their action or inaction.

4. If your child takes personal belongings on this field trip, he or she will be responsible for them. The School Board accepts no responsibility for personal items, such as watches, purses, money, cameras, and wallets, etc. If a student stores personal items in a locker at an amusement park, that entity may be responsible for any loss or damage.

______________________________________ _________________
Signature of parent/guardian                                                     Date

NOTES:
1. THIS BLANKET FORM MAY BE USED FOR TRIPS OF A SIMILAR NATURE, WHICH ARE REPEATED DURING THE SCHOOL YEAR.
2. FOR ALL OUT-OF-COUNTY TRIPS, A NOTARIZED MEDICAL TREATMENT AUTHORIZATION FORM MUST ALSO BE AVAILABLE. THE MEDICAL FORM MUST BE COMPLETED PRIOR TO THE STUDENT'S FIRST OUT-OF-COUNTY TRIP AND SHOULD BE RETAINED FOR USE DURING THE REMAINDER OF THE SCHOOL YEAR.

All students may be asked to provide transportation to and from events. Students are required to stay for the entire event and are not permitted to leave unless the instructor for the event has been notified and the parent/guardian has given permission for the student to leave. Please sign below if you will allow your student to drive to and from the event.

____________________________________________________________
Parent/Guardian
10-Panel Drug Screening

The students in the CNA Program are required to have a 10-Panel drug screening. The Medical and Public Safety Academy has made arrangements to have this testing done on campus for an approximate fee of $18.00. This is a one-time only deal. If you do not get the testing done at this time, it will be up to you to have the testing done by the deadline given. Students are not allowed to go to clinical training without this test. Students need to bring this paper signed by a parent or guardian and a driver’s license, Florida ID card, or Passport for this test. You must also bring your social security card, if you do not know the number. Testing will take place in the Nursing Assistant Class and Lab.

I am giving the Polk County School Board permission to test my student.
Student Name:____________________________________________________
Student Signature:_________________________________________________
Parent Name:_______________________________________________________
Parent Signature:____________________________________________________
Please declare if you are taking any prescribed or over the counter medications:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________