“Returning Participant”

Check program:
- Nursing (RN)
- Nursing (PN)
- Respiratory Therapy
- Certified Nursing Assistant
- Phlebotomy

All sections of this health form must be completed in order to be eligible to participate in both clinical and classroom activities.

Please upload completed form to ACEMAPP using directions provided by the Nursing Program Coordinator (RN and PN students only). Students in all other programs to submit documents to program leads. Student must be able to meet all technical standards as listed below.

Note: Specific examples of Technical Standards can be found on the back of this page.

<table>
<thead>
<tr>
<th>Critical Thinking:</th>
<th>☐ Sufficient critical thinking and cognitive abilities in classroom and clinical settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism:</td>
<td>☐ Interpersonal skills sufficient for professional interaction with a diverse population of individuals, families and groups</td>
</tr>
<tr>
<td>Communication:</td>
<td>☐ Communication sufficient for professional interactions</td>
</tr>
<tr>
<td>Mobility:</td>
<td>☐ Physical abilities sufficient for movement from room to room and in small spaces</td>
</tr>
<tr>
<td>Motor Skills:</td>
<td>☐ Gross and fine motor abilities which are sufficiently effective and safe for providing allied health care</td>
</tr>
<tr>
<td>Sensory:</td>
<td>☐ Auditory and visual ability sufficient for observing, monitoring and assessing health needs</td>
</tr>
<tr>
<td>Observation:</td>
<td>☐ Ability to sufficiently make observations in a health care environment, consistent with program competencies</td>
</tr>
<tr>
<td>Tactile Sense:</td>
<td>☐ Tactile ability sufficient for physical assessment</td>
</tr>
</tbody>
</table>

Is the individual free of contagious illness? ☐ Yes ☐ No
If No, please explain: ____________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

☐ I do hereby give my consent for the individual to fully participate in the classroom and clinical activities including complete patient care.

Additional Comments: __________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

____________________________________________________________________________

_________________________________________________                                _____________________
Health Care Provider Signature                                                                         Date

____________________________________________________________________________

Please affix sticker or stamp with Provider name and address            Phone number

Note: All costs associated with this exam are the responsibility of the individual.
<table>
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<th><strong>Examples</strong></th>
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Name: ___________________________________________ 
Student ID: _________________________
(Please Print)

**Tuberculin Testing Student Tuberculosis (TB) Testing**

After admission (annually), students must provide proof of negative TB status by submitting one of the options below:

1. A single annual TB screening schedule can be maintained every year.
2. Approved TB screening blood test.
3. If a person has a previously documented positive TB screening test or a documented diagnosis of TB or Latent TB Infection (LTBI) in the past, see option 3 below.

Name: ____________________________________    Student ID: _________________________
(Please Print)

**OPTION 1: 1-Step TST**

One STEP OF THE TB SKIN TEST (TST):
Date Test Given (mm/dd/yyyy): ______________ Test Given by: _______________________________
Site: □ Left Forearm □ Right Forearm Manufacturer/Lot #: _______________________________

Date Test Read (mm/dd/yyyy): ______________ Test Read by: _______________________________
Interpretation: □ Negative □ Positive Measurement of Induration (in millimeters): mm

--- OR ---

**OPTION 2: TB Screening Blood Test**

INTERFERON-GAMMA RELEASE ASSAY (IGRA) – Quantiferon or T-Spot:
Date Test Given (mm/dd/yyyy): ______________ Test Given by: _____________________________

Interpretation: □ Negative □ Positive

**In the event of a positive result: If a tuberculin skin test or the IGRA blood test is positive or a person exhibits signs and symptoms suspicious for tuberculosis, a medical evaluation is required.**

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**OPTION 3:**

If a person has a previously documented positive TB screening test or a documented diagnosis of TB or Latent TB Infection (LTBI) in the past, perform an annual risk assessment/symptom check with your healthcare provider instead of the TST or IGRA. Repeat Chest x-ray is only required if symptoms develop.

**CHEST X–RAY**

Documentation that the Chest X-Ray was performed to rule-out tuberculosis due to a positive TB skin test, IGRA blood test or due to the development of signs or symptoms of tuberculosis must be in the Chest X-Ray report or comments.

Date of Chest X-Ray (mm/dd/yyyy): __________________
Interpretation: □ Normal □ Abnormal

Healthcare Provider Signature: _________________________ DATE: __________________________

Symptom Review Statement:

_________________________________________________________________________________

_________________________________________________________________________________

Health Care Provider Signature Date
_________________________________________________________________________________

_________________________________________________________________________________

Please affix sticker or stamp with Provider name and address Phone number