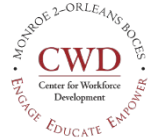




Center for Workforce Development



# Nurse Assisting - Medical Clearance Form

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Student Address: \_\_\_\_\_

Tel#: \_\_\_\_\_ Email: \_\_\_\_\_

Latex Allergy: Yes / No

Allergies: \_\_\_\_\_

Medication & Supplements (List All) \_\_\_ None  
\_\_\_\_\_

Date: (within 6 months of class start date)	Height	Blood Pressure	Weight	Pulse

Please circle findings. Comment only if abnormal.

Hand/skin: normal / abnormal

Comment: \_\_\_\_\_

Head/eyes: normal / abnormal

Comment: \_\_\_\_\_

Ears/nose/throat/mouth: normal / abnormal

Comment: \_\_\_\_\_

Neck/nodes: normal / abnormal

Comment: \_\_\_\_\_

Chest/lungs: normal / abnormal

Comment: \_\_\_\_\_

Cardio/vascular: normal / abnormal

Comment: \_\_\_\_\_

Abdomen: normal / abnormal

Comment: \_\_\_\_\_

Musculoskeletal/extremity/spine: normal / abnormal

Comment: \_\_\_\_\_

Nervous system/seizure disorder: normal / abnormal

Comment: \_\_\_\_\_

Genito/urinary: normal / abnormal

Comment: \_\_\_\_\_

Name: \_\_\_\_\_ Program: \_\_\_\_\_

**IMMUNIZATIONS: Please mark date of Vaccination & Lot number, or proof Titer**

Administered Dates	#1	#2	#3	#4	Required or Optional?
MMR (Measles, Mumps, Rubella)	Date: Lot #	Date: Lot #			Required
HEP B Vaccine (series)	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	Optional
Sars-Cov-2 Vaccine	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	Required
Influenza Vaccine (seasonal)	Date: Lot #				Optional (masking required if not complete)
PPD SKIN TEST  Date Placed :	Date Read:	Read By :	Lot Number #	Results:	Required

Positive PPD, chest X-ray results: \_\_\_\_\_ Date: \_\_\_\_\_

Result (circle one): Normal / Abnormal (Mo/Day/Yr.)

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**Does this patient suffer from any chronic physical or mental disabilities and or limitations that would interfere with patient care for a period of 6 hour to 12 hour working days?**

YES or NO, if YES, please explain:

\_\_\_\_\_

\_\_\_\_\_

*To the best of my knowledge the above-named patient has been medically cleared to participate in clinical work and/or education at this time.*

**Physician's Name:** \_\_\_\_\_  
*Print* *Date*

**Physician's Signature:** \_\_\_\_\_  
*Sign* *Date*

**Physician's Office Stamp:**

## **Instructions for Completing the Medical Clearance Form**

*For ALL students taking the BOCES 2/CWD Adult Education  
Nurse Assisting Program*

It is a **New York State mandate** that in order for you to participate in either of these programs, the attached medical form must be completed and submitted.

Below are the steps that will assist you with completing this form prior to enrollment.

1. Please have the Medical Clearance Form completed by a physician.
  - Students without a primary care physician may be able to complete the form through an urgent care facility, such as WellNow Urgent Care Clinic at 2232 Lyell Ave, 585-417-4125.
2. **ALL** fields must be filled out **by your doctor(s)** prior to entering into the "clinical" portion of either program.
3. The medical form **must be signed, dated and stamped by your doctor(s) in order for BOCES 2 CWD to accept the document.**
4. It is **recommended** that you pick up the original medical form from your doctor(s) and make a copy for your records.
5. It is **recommended** that you drop off the medical form to the BOCES 2 Center for Workforce Development Main Campus office located at 3555 Buffalo Road, Rochester NY 14624. **You may have your physician fax it with your proper consent to: (585) 349-9101 Attention: Admissions**

Please note that it is **YOUR RESPONSIBILITY** to ensure that this medical form is completely filled out, signed, dated, and stamped by your doctor and turned in to the BOCES 2/CWD office.

*\*\* If you unable to get this form completed by your doctor before the start of your program, A Medical Clearance Confirmation Form MUST be completed which will confirm that an appointment has been made. \*\**

If you have any questions, please do not hesitate to call us at (585) 349-9100 for assistance.

## Medical Clearance Confirmation Form

Student Name: \_\_\_\_\_

Program: \_\_\_\_\_ Start Date: \_\_\_\_\_

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This form certifies that you have acquired a doctor's appointment to have your medical clearance form completed.

Date of Appointment: \_\_\_\_\_

Time: \_\_\_\_\_

Physician: \_\_\_\_\_

**Please attached proof from your doctor's office with confirmation of appointment.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*By completing this form, you understand that your medical clearance form must be completed, with all requirements fulfilled, within **30 days** of this form or you will be ineligible to participate in clinical and complete your program to receive your certificate of completion.\*\***