



KISHWAUKEE COLLEGE

BNA Course Preparation Checklist

We are excited to have you take the Basic Nurse Assisting Course, NUR 100. We look forward to helping you on your journey to become a Certified Nurse Assistant (CNA).

Before attending your first Basic Nurse Assistant class, the following requirements must be completed. Failure to complete the following tasks will cause a delay and possibly prevent you from being able to take the course or complete the course objectives. Provide this completed checklist to the course coordinator upon completion for review and verification of all results required. To ensure completion of course preparation requirements, it is suggested to **start at least two weeks before the course starts**.

ITEMS TO COMPLETE

- ☐ Drug Testing – Dekalb County Health Department
- ☐ Background check form completed
- ☐ Fingerprinting (if instructed to complete by course coordinator)
- ☐ Kishwaukee student ID (must have for clinicals)
 - Student IDs are created in Student Services, C2100. You will need your schedule and a photo ID
- ☐ Tb test – A copy of a recent Tb test (within the last year)
- ☐ Copy of COVID vaccination card
- ☐ Influenza (vaccine proof or declination form)
- ☐ Copy of current BLS/CPR card (must be from American Red Cross or American Heart Association and not expired)
- ☐ Copy of Social Security card
- ☐ Course requirements and program policies paper
- ☐ Student Information form
- ☐ Safety Agreement
- ☐ Obtain your class materials in the Kishwaukee College Bookstore.
 - Textbook
 - Stethoscope
 - B/P cuff
 - Gait belt
 - One uniform (top and bottoms)

Please sign and return once all requirements have been complete.

Student Signature _____ Date _____

Course Preparation Information and Instructions

Drug Screening

DUE: Results due by first day of course

BRING WITH YOU: State approved photo ID

WHEN: One week prior to first day of class

DAYS: Monday, Wednesday, and Fridays

TIME: 8:30 a.m. - 12:00 p.m. and 1:00 p.m. - 4:00 p.m.

LOCATION: Dekalb County Health Department

2250 North Annie Glidden Road

Dekalb, Illinois, 60115

No appointment necessary. Dekalb County Health Department has a list of students enrolled for this course. Please contact the Health Department at (815)-748-2420 if you require an appointment outside of the hours provided.

Fingerprinting

You will need to complete the fingerprinting authorization document and return it to the course instructor Ashley Foltz, RN. (Form: "Privacy Act Statement" located in this packet). Available on campus Mondays from 8:00 a.m. - 12:00 p.m. or deliver to Health Sciences office (B1222). **Fingerprinting must be completed before the course starts per state regulations.** If you are currently or have worked in healthcare previously, your fingerprints may already be in the system. However, the authorization form is still **required** for verification.

DUE: completed before start of course

BRING WITH YOU: State approved photo ID

WHEN: You are responsible for scheduling this appointment. Appointment hours: 10:00 a.m. - 2:00 p.m.

Contact: Fingerprint Technician, Office Assistant

Dekalb County ROE#16

2500 Annie Glidden Road, Suite C

Phone: 815-217-0460

****Results may take up to two weeks! You may NOT attend clinical without them.**

TB Testing

A two-step TB test or QuantiFERON Gold Lab draw must be completed by the end of the first course week. This can be completed at the Health Department, your physician's office, or some walk-in clinics. **The cost is not included in the tuition and fees for this course.** You will be responsible for any charges related to obtaining this test.

COVID Testing

A negative COVID test is required before the clinical experience begins. **DO NOT HAVE THIS DONE UNTIL INSTRUCTED.** The specific time for testing will be provided during the first week of the course.

COVID Vaccine

The COVID vaccine is **REQUIRED** for all clinical experiences. A copy of your current COVID vaccinations will need to be provided with your preparation paperwork.

CPR

A current CPR card from the American Heart Association or American Red Cross is REQUIRED and will need to remain active through your certification examination. Please contact the Health Sciences Division at Kishwaukee College if you require assistance with finding a CPR course.

Social Security or ITTN card

The Illinois Department of Health requires that a copy of your CPR card and Social Security or ITTN card are on file with your course coordinator.

Background Check Form

This form is available on the last page of this packet. Print the form and return it to the course coordinator before the course starts. Printing is available at the Kishwaukee College library on campus.

Fingerprinting Form

Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearance, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprints repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Applicant Consent

By signing below, I acknowledge and hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution, or entity having such information on file. I am aware and understand that my fingerprints may be retained and will be used to check the criminal history record information files of the Illinois State Police and/or Federal Bureau of Investigation, to include but not limited to civil, criminal, and latent fingerprint databases. I also understand that if my photo was taken, my photo may be shared only for employment or licensing purposes. I further understand that I have the right to challenge any information disseminated from these criminal justice agencies regarding me that may be inaccurate or incomplete pursuant to Title 28 Code of Federal Regulation 16.34 and Chapter 20ILCS 2630/7 of the Criminal Identification Act.

Applicant Name (printed):	
Applicant Name (signature):	Date:

THIS SIGNED FORM MUST BE RETAINED BY THE AGENCY FOR AT LEAST TWO YEARS.



KISHWAUKEE COLLEGE

Basic Nursing Assistant Training Program - Course Requirements and Program Policies

My signature below indicates that I have read the Nursing Assistant Training Program (NUR 100) course syllabus. I am aware of my responsibility to meet the Basic Nursing Assistant requirements and follow the program policies.

I will complete all written/ "hand-in" assignments, as directed in the syllabus, prior to class completion. I am aware that I am responsible for completing all exams, assignments, and discussion board submissions (as required by the syllabus),

I will maintain a professional appearance and attitude during my course and clinical experiences.

Failure to sign, date and submit this agreement to my instructor means I am not interested in continuing the Basic Nursing Assistant Program.

Student Signature: _____

Date: _____

Student Information Form

Student Name: _____

Address: _____

Cell Phone Number: _____

If there is a medical emergency, the college representative will first use reasonable efforts to call the provided contact(s) and/or guardian(s) before administering or arranging any treatment. Please complete the following pages with the appropriate information.

Students are expected to remember that they are participating in this clinical experience as representatives of Kishwaukee College and must follow the Code of Student Conduct and Discipline as laid out by the college. Failure to abide by rules determined by the Code of Student Conduct, or rules employed by the college representative on the trip will be turned over to the Dean of Student Services for further action.

Please stay in close contact with the college representative and respond to calls and messages received. Notify the college representative immediately if assistance is needed.

Signature of Student

Date

Signature of Parent/Guardian
(if student is under the age of 18)

Date

Student Information Form

Student's Name:

Student's Nickname/Preferred Name:

Student's Age:

Parent(s) and Other Contacts

Primary Contact Name:

Relationship:

Phone Number:

Secondary Contact Name:

Relationship:

Phone Number:

Medical/Health/Insurance Care Information

Student's Primary Doctor:

Address:

Office Telephone:

After Hours Number:

Medications:

Allergies:

Immunizations:

Special Conditions:

Please provide any additional information that may be helpful on the back

Basic Nursing Assistant Training Program – Safety Agreement for Nursing Laboratory Use

This agreement is part of your introduction to the Nursing Laboratory. In addition to reviewing the list below, your instructor will give you a “tour” of the laboratory to acquaint you with the general layout.

Any safety hazards that might be associated with the day’s procedures will be covered at the beginning of each lab. **DO NOT BE LATE FOR LAB!** If you should happen to be late, you may not be able to do the procedures that day. Your only other options are to come to another lab session or meet with the lab/skills specialist for practice on your own time over concepts missed.

Safety will play a particularly key role in your lab evaluations. When you are in the laboratory, THINK about what you are doing at all times. Be sure to practice the following safety regulations:

1. Absolutely no unauthorized procedures should be attempted.
2. No eating, drinking, or smoking is allowed in the laboratory.
3. No solitary work by students is permitted in the laboratory.
4. Keep the laboratory clean (especially sinks). Clean off your area after practice and procedures.
5. Wash hands before and after procedures.
6. Immediately report all accidents that cause injury, no matter how minor, to the instructor or nursing administration.
7. Standard Precautions recommended by the CDC are to be adhered to at all times.
8. The presence of children or non-nursing students is not permitted.
9. Electrical equipment is used safely, and defective equipment is reported to the instructor or nursing administration immediately.
10. Report all broken or damaged equipment immediately to the instructor.
11. Needles must be locked up after use or discarded in the sharp's containers.
12. Lock wheelchairs before transferring client.
13. Raise side rails and raise beds to working height before practicing procedures.
14. Do not use any electrical equipment that is damaged or has frayed cords. Any electrical equipment requiring repairs or maintenance will be unplugged before maintenance is performed.
15. Comply with the COVID 19 lab plan.

I understand that I will be held accountable and responsible for the materials contained in the laboratory supply kits. It is further understood that **the materials are for lab practice use only and are not to be used on any other person including self, peers, family member or parents.**

I have read the Safety Agreement for the Nursing Laboratory and recognize that it is my responsibility to observe the regulations throughout my nursing/health sciences course. Failure to do so may result in my being dropped from this class or receiving a failing grade.

Printed Name: _____

Signature: _____ Date: _____



KISHWAUKEE COLLEGE

Student/Employee Influenza Vaccination Acceptance/Declination Form

Student/Employee Name: _____

Program: _____

1. _____ (initial) I have read the "Influenza Vaccine Information Statement". I have had the opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I intend to be vaccinated.
2. I acknowledge that I am aware of the following facts:
 - Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year
 - Influenza virus may be shed for up to 48 hours before the symptoms begin, allowing transmission to others.
 - Up to 30% of people with influenza have no symptoms, allowing transmission to others.
 - Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2-6 months.
 - I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all diseases.
 - I have declined to receive the influenza vaccine for this flu season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family, and my community.
 - I may not be allowed to participate at certain clinical agency sites due to declination of the influenza vaccine based on site specific policies.
 - During the flu season I will be required to always wear a face mask during my clinical experiences.
3. After reading the "Influenza Vaccine Information Statement," I decline the vaccination for the following reasons (please select all that apply)

_____ My philosophical or religious beliefs prohibit vaccination

_____ I have a medical contraindication to receiving the vaccine

_____ Other reason: _____

_____ I do not wish to answer reason for declination

Knowing the facts set forth above, I choose to decline vaccination at this time. I may change my mind and accept vaccination later if vaccine available. I have read and fully understand the information on this declination form.

Student/Employee Signature _____

Date: _____