2345 E 8th Street, Suite 113 • National City, CA 91950
Office: (619) 488-3460 • Fax: (619) 488-3479

VOCATIONAL NURSING PROGRAM

Class of 2024 - 2025

Schedule of Classes and Program Cost

The Vocational Nursing Program is a 1554-hour / 52-week program. The school believes that nursing is a scientific discipline with a distinct body of knowledge, manifested by the art of caring. The school facilitates learning through a variety of approaches such as developing material, selecting learning strategies and resources, implementing teaching strategies, stimulating discussions, participating in dialogue, monitoring/evaluating student progress, adjusting curriculum to meet student needs, and reporting progress.

Below is the schedule of classes and the fees for the Vocational Nursing Program.

Schedule of Classes		
Theory/Classroom/Skill Lab	Monday through Friday	8:00 AM - 4:30 PM (Varies)
Clinical Rotation	Monday through Friday	7:00 AM - 3:30 PM

Program Cost		
Tuition		$37,775
ATI and Swift River Platform		$2170
Registration Fee		$100
STRF – Nonrefundable		$0
Uniforms (4 Sets of Uniforms with School Logo)		$350
Textbooks, Materials and Misc*		$ 1000
	Total	$41,395

Textbooks:

Anatomy and Physiology for Health Professional, 4th Ed.

Foundations and Adult Health Nursing, 9th Ed by Cooper and Gosnell

Saunders Comprehensive Review Book

Nursing Drug Handbook (Current Year)

***Miscellaneous:** Littmann Stethoscope and Background Check

Vocational Nurse Program Application Checklist

Academic Requirement

- Form A: Student Registration _____
- High School Diploma, GED or Equivalency _____
- Test of Essential Academic Skills (ATI TEAS) Exam at Proficient Level _____
- Submit an Essay on "Why Do I Want to Become a Nurse?" _____
- Ability to Communicate Fluently in both Written and Spoken English* _____

Health Assessment

- Form B: Health History _____
- Form C: Physical Examination and TB Clearance _____
- Form D: Immunization/Titer Results _____

Background Check

- Complete Live Scan _____
- Complete Drug Screening _____

Note:

Submission of an application does not guarantee acceptance.

For transfer credit, please contact the student coordinator for Credit Granting Policy.

*For those whose first language is other than English, we encourage students to take ESL classes offered at Community Colleges.

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PROGRAM: ❒ Vocational Nurse ❒ Nurse Assistant

FORM A: STUDENT REGISTRATION

(This section to be completed by the student. Please use ink and print clearly)

Name: _____ DOB: _____

Address: _____

Phone Number: _____ Email Address: _____

Social Security: _____

Emergency Contact: _____ Contact Number: _____

For statistical purposes only, identify yourself in one of the following groups:

❒ Hispanic, Mexican ❒ Asian/Pacific Islander Other, specify: _____
❒ White ❒ American Indian
❒ Black ❒ Filipino

Are you able to perform the essential job functions of the profession/career you are applying with or without reasonable accommodations? ❒ Yes ❒ No

Do you primarily speak a language other than English? ❒ Yes ❒ No

What is that language? _____

How well do you speak that language? ❒ Very well ❒ Well ❒ Not very well

Do you require English language assistance? ❒ Yes ❒ No

How well do you speak English? ❒ Very well ❒ Well ❒ Not very well ❒ Not at all

PLEASE READ AND SIGN:

The information submitted in this application packet is complete and accurate. I understand that falsification of any information on this application may be cause for non-selection or dismissal from the program.

_____ _____

Student Signature Date

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FORM B: HEALTH HISTORY

(This section to be completed by the student. Please use ink and print clearly)

Name: _____ DOB: _____

Allergies (Drugs/Food): _____

Current Medications: _____

Past Medical History

- ❒ Alcoholism
- ❒ Anemia
- ❒ Arthritis
- ❒ Asthma
- ❒ Autoimmune disorder
- ❒ Bleeding Problem
- ❒ Other:
- ❒ Cancer; Type
- ❒ Depression
- ❒ Diabetes
- ❒ Epilepsy (seizure disorder)
- ❒ High cholesterol
- ❒ High Blood Pressure
- ❒ Osteoporosis
- ❒ Prostate problems
- ❒ Stroke
- ❒ Thyroid disorder

Past Surgical History

Type of surgery: _____

_____

_____

_____

When: _____

System Review

In the past month, have you had any of the following problems?

General
- ❒ Weight loss
- ❒ Weight gain
- ❒ Fatigue or weakness
- ❒ Fever, chills, or night sweats

Muscle/Joints/Bones
- ❒ Muscle weakness
- ❒ Numbness
- ❒ Joint Pain
- ❒ Joint swelling

Ears
- ❒ Loss of hearing

Eyes
- ❒ Loss of vision

Throat
- ❒ Frequent sore throats

Heart and Lungs
- ❒ Chest pain
- ❒ Palpitations

Nervous System
- ❒ Headaches
- ❒ Dizziness
- ❒ Fainting or loss of consciousness

Stomach and Intestines
- ❒ Nausea
- ❒ Heartburn
- ❒ Stomach pain
- ❒ Vomiting
- ❒ Constipation
- ❒ Persistent diarrhea

Skin
- ❒ Redness:
- ❒ Rash

Blood
- ❒ Anemia
- ❒ Clots

Kidney/Urine/Bladder
- ❒ Frequent or painful urination
- ❒ Blood in urine

Psychiatric
- ❒ Anxiety
- ❒ Depression
- ❒ Excessive worries
- ❒ Insomnia
- ❒ Poor appetite
- ❒ Thoughts of suicide/attempts
- ❒ Irritability
- ❒ Poor concentration
- ❒ Mood swings

Other symptoms:

Immunizations:

MMR _____

Hepatitis B _____

Tetanus _____

Varicella _____

TB Screening _____

Influenza _____

Student Signature: _____ Date: _____ Provider Initials: _____

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FORM C: PHYSICAL EXAMINATION

(This section to be completed by the DO, MD, NP or PA only)

Name: _____ DOB: _____ Social Security: _____

Gender: ❒ Male ❒ Female Height: _____ Weight: _____

Vital Signs: _____ Pulse: _____ RR: _____ Temp: _____

Vision OS: _____ OD: _____ Hearing R: _____ L: _____

System	Function WNL		
	Yes	No	Comment
General			
HEENT			
CV			
Pulmonary			
GI			
GU			
Neurological			
Integument			
Musculoskeletal			
Immune system			
Endocrine			
Mental Health			

Function	Ability to Perform		
	Yes	No	Comment
Able to work standing, sitting, bending, and lifting			
Able to use all physical senses			
Able to perform fine motor skills			
Able to coordinate physical and mental activities to perform tasks or skills safely			
Does not have health conditions that create a hazard to self or others			
Are there recommendations for continued medical care			

Healthcare Provider Name: (Printed/Stamped): _____

Signature: _____ Date: _____

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FORM C: PHYSICAL EXAMINATION (CONT)

(This section to be completed by the DO, MD, NP or PA only)

Tuberculosis Clearance

Student must submit TB clearance form only 1 of the 3 options described below:

1. **TB PPD Skin Test.** Note: A 2-Step TB PPD (2nd PPD must be administered at least 10 days from the 1st PPD being administered) is required if the student has not had a PPD in more than 1 year, or 365 days.

Having a history of BCG vaccine alone is not acceptable as a positive PPD history unless a skin test has been given and the result was 10 mm or greater.

2. **IGRA (e.g., QuantiFERON or T-spot).** Lab report must not be more than 6 months from the first day of matriculation. In addition, student must submit a completed TB Symptoms Checklist.
   IGRA Date: _____
   (Note: This test is valid for 4 years at The Nurse Academy).
3. **Chest X-Ray/Radiology Report.** If student has a positive PPD history, a current X-Ray report must not be more than 6 months from the first day of matriculation is required. In addition, student must submit a completed TB Symptoms Checklist.
   Chest X-Ray date: _____

Two Step Tuberculosis (TB Screening)

TB Skin Test: 5 tuberculin units (TU)/0.1 mL administered intradermally.

Test #1		
Date: _____	Site: _____	Signature: _____
Reading: _____	mm induration: _____	mm erythema: _____
Results: ❒ Positive ❒ Negative	Signature: _____	

Test #2		
Date: _____	Site: _____	Signature: _____
Reading: _____	mm induration: _____	mm erythema: _____
Results: ❒ Positive ❒ Negative	Signature: _____	

Healthcare Provider Name: (Printed/Stamped): _____

Signature: _____ Date: _____

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FORM D: IMMUNIZATION/TITER RESULTS

(This section to be completed by the DO, MD, NP or PA only)

Name: _____ DOB: _____

Vaccine	Titer	Series #1	Series #2	Series #3
Hepatitis B*	Titer: _____ Date: _____ B Surf Ab, Quantitative QN	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	Date: _____ (6 Months after #1)
Measles (Rubeola)**	Titer: _____ Date: _____ Rubeola AB, IgG, EIA	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Mumps**	Titer: _____ Date: _____ Mumps AB IgG	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Rubella**	Titer: _____ Date: _____ Rubella AB IgG	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Varicella**	Titer: _____ Date: _____ Varicella AB IgG	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Tetanus Diphtheria Acellular Pertussis (Tdap)		Date: _____ Note: Td/Dtap will not be accepted.		

*Note: If a student has received 2 complete Hepatitis B series (one series consists of 3 vaccines) and the titer still shows no immunity, then student must provide proof of 2 complete vaccination series before the student can be declared a Hepatitis B non-converter. Once declared a non-converter, the student will not be required to receive any more Hepatitis B vaccines.

**Note: If titer results for Measles, Mumps and Rubella (MMR), and Varicella are negative or inconclusive/equivocal and there is no documentation showing completion of MMR and Varicella vaccine series (2 vaccines), then student must start the vaccination series which is 2 immunizations 30 days apart.

Healthcare Provider Name: (Printed/Stamped): _____

Signature: _____ Date: _____

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TB SYMPTOMS CHECKLIST

(This form only applies to those required to have a Chest X-Ray or have had an IGRA (QuantiFERON test))

Name: _____ DOB: _____

Have you ever had a BCG vaccination? ❒ Yes ❒ No
(If yes, it is preferred that you obtain an IGRA (e.g., QuantiFERON or T-spot test)

Date of last PPD: _____ Results: _____ mm

Date of IGRA (e.g., QuantiFERON or T-spot test): _____ Results: _____

Date of last Chest X-Ray: _____ Results: ❒ Positive TB ❒ Negative TB

Have you ever been told you have active tuberculosis? ❒ Yes ❒ No

Have you ever taken Isoniazid (INH) or Rifampin (RIF)? ❒ Yes ❒ No

Date and duration of medication regimen: _____ (months)

During the past year, have you noticed:	
Unexplained weight loss?	❒ Yes ❒ No
Decrease in your appetite?	❒ Yes ❒ No
Cough not associated with cold or flu?	❒ Yes ❒ No
Increase in amount of sputum?	❒ Yes ❒ No
Change in color of sputum?	❒ Yes ❒ No
Blood streaked sputum?	❒ Yes ❒ No
Night sweats?	❒ Yes ❒ No
Unexplained low-grade fever?	❒ Yes ❒ No
Unusual tiredness or fatigue?	❒ Yes ❒ No
Enlarged lymph nodes?	❒ Yes ❒ No
Have you had contact with a family member or partner who has been diagnosed with tuberculosis?	❒ Yes ❒ No
Have you or a member of your family been exposed to someone who is immune compromised?	❒ Yes ❒ No

Explain any "yes" answers: _____

List any on-going medical problems: _____

_____ _____

Student Signature Date