HAWAII HEALTHCARE SCHOOL

1314 South King St. Ste. 622, Honolulu, Hi 96814

Nurse Aide Enrollment Form

Name: _____ Contact #: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Email: _____

Emergency Contact:

Name: _____ Relationship: _____ Contact: _____

Uniform Size: □ X-Small □ Small □Medium □ Large □ X-Large □ 2XL

How did you find us: Friend:_____ Family_____ Internet:_____ Other: _____

□ **Japanese Course Cost:**
Total cost..... $1,680.00

A deposit of $300 must be paid at time of registration.

Agreement is binding: This agreement will be binding only when it has been fully completed, signed and dated by the student and an authorized representative of the school prior to the time instruction begins.

Changes in the agreement: Any changes in the agreement will not be binding on either the student or the school unless such changes are acknowledged in writing by an authorized representative of the school and by the student. We reserve the right to cancel classes for any reason or postpone classes due to insufficient enrollment. Every effort will be made to notify you of a cancelled class well in advance. If we cancel a class, you will receive a full refund of the class fees paid. In the event that you decide to withdraw, a refund may be given if a written or personal cancellation is received at least 3 working days prior to start of class. No refund granted after. Telephone cancellation is not accepted. There is a $60.00 cancellation fee to cover administrative costs and returned book.

Effective date of acceptance: I hereby agree to abide by the conditions set forth herein. I declare that I am 18 years or older, a high school graduate, and no criminal record.

I certify that I, _____ have no history of conviction of any felony, such as theft, abuse, assault, neglect, or drug use.

Signature _____ Date _____

Office use only:
School Representative: _____ Date: _____

Deposit: □ Cash □ Check #

HAWAII HEALTHCARE SCHOOL

1314 South King Street #622, Honolulu, Hawaii 96814
Phone: (808) 791-5825 Fax: (808) 791-5839

Physical Health Clearance Form

Name: _____ Last 4 digits of SSN: _____ Contact: _____
(Last) (First) (Middle)

Email: _____ Gender: M F

Address: _____
(Street) (City) (State) (Zip Code)

SECTION 1: (Student must complete this part prior to exam)

Drug allergies _____ Food Allergies or intolerance _____
Does Student require epi-pen? Yes No Has student been trained to use it? Yes No
List of Medications (Please include prescription medication and any over-the-counter medications taken daily):

Past Medical History

o Frequent headaches	o High Blood Pressure	o Frequent ear/sinus infections	o Surgery
o Epilepsy/seizures	o Pneumonia frequent	o Diabetes	o Scarlet fever
o Thyroid disorder	o Tuberculosis	o Kidney/urinary infections	o Hernias
o Bleeding disorders	o Mononucleosis	o Rheumatic fever	o Cancer
o Asthma	o Stomach/bowel problem	o Heart Disease	o Hepatitis
o Hypoglycemia	o Menstrual disorder	o Skin/bone/joint disease	o Anemia

Family Medical History

o Diabetes	o Heart Disease	o High Cholesterol
o Tuberculosis	o Hypertension	o Cancer
o Epilepsy/seizures	o Asthma/COPD	o Blood Disease

SECTION 2: HEALTHCARE PROVIDER

Height: _____ Weight: _____ BMI: _____ Temp: _____ Pulse: _____
Resp.: _____ BP: _____Vision: R _____ L _____ (corrected or uncorrected) Hearing: _____
o Routine urinalysis: _____ (Completed date)
2-stepTB clearance:

Step 1 (right/left forearm)		**Step 2 (right/left forearm)**	
Date given:	**By:**	**Date given:**	**By:**
Date read:	**By:**	**Date read:**	**By:**
Results: _____ mm induration (0mm = neg.)		**Results: _____ mm induration (0mm = neg.)**	

- **Date of last CXR (if applicable): _____ Results: _____**

Student is cleared for all physical education and/or athletic activities YES NO
If no, please explain:

_____
_____

Are there any emotional issues/concerns that school should be aware of to assist the student in achieving his/her educational goals?
YES NO If yes, please explain

_____
_____

Healthcare provider's Name: _____ Date: _____

Signature: _____ License No. _____
Address: _____ Phone #: _____

This form will not be accepted without healthcare provider's signature and information listed. (Stamp is acceptable)

HAWAII HEALTHCARE SCHOOL

Certified Nurse Aide Training
入学にあたって
特に CNA 受験を希望する方へ

Hawaii Healthcare School – Nurse Aide class is an English based class with Japanese translation. Therefore, prospective students are required to have working comprehension of English, (i. e. speaking, reading, writing, listening, etc.). Especially, if you plan to take the State of Hawaii certification test.

It is Not a 100% Japanese Nurse Aide class.

ハワイ ヘルスケア スクール --- ナースエイドクラスは基本英語のクラスとなりますが、日本語のお手伝いが付きます。従いまして、このコースへの入学希望者は最低限の基本的な英語の読解力等が必要となります（たとえば、スピーキング、リーディング、ライティング、リスニングなどです）。特にハワイ州の CNA 受験を考えている方は上記の能力が必要となります。

このコースは 100％日本語のナースエイドクラスではありません。

Print Name/お名前 _____.

Signature/ご署名 _____ Date _____.