Basic Nursing Assistant Training Program Physical Examination Form

To The Student: Please have this form completed by a licensed physician or licensed nurse practitioner. Bring the original completed physical form/personal health history and all laboratory (titer results/10 panel drug screen) and two-step TB results with you on the first day of class. Students without this completed form will not be allowed in the clinical facility.

Vital Signs: Temperature _______ Pulse _______ Blood Pressure _______ Height _____ Weight _______

Record Findings, Indicating Normal and Abnormal

- Skin and Nails
- Mouth & Pharynx
- Breasts
- Peripheral Vascular
- Head
- Neck
- Abdomen
- Musculoskeletal
- Eyes
- Nerves
- Genitalia
- Neurological
- Ears
- Thorax
- Rectum
- Mental Status
- Nose & Sinuses
- Heart

Special note: Pregnancy does not prevent a student from participation in the program, but it is necessary that you advise your instructor of your condition and obtain a note from your physician giving permission to fully participate in all activities.

Describe any abnormality in detail.

Please list any prescribed medications/treatments the student is receiving:

On the basis of your history and physical examination, is it your professional opinion that this person is capable of participating in a Basic Nursing Assistant Training Program? □ Yes □ No

What restrictions, if any, would you advise?

Any allergies?

Drug sensitivities?

Hepatitis B Vaccines: Recommended, but not mandatory.

Dates: Dose 1 ___________ Dose 2 ___________ Dose 3 ___________

If you have had all 3 Hepatitis 3 vaccines and can’t remember the dates or your provider orders an antibody test for Hepatitis Immunity—please provide a copy of your titer results.

Required Vaccinations: Tetnus/diphtheria/pertussis (TDap): must be given within the last 10 years. Each student must provide proof of receiving at least one acellular pertussis (Tdap) vaccine.

Date of Tdap vaccine: ______________________________

Flu vaccine is required for students enrolled in the CNA program fall semester second 8-week classes or spring semester first 8-week classes.

Tuberculin Skin Test
#1 Date given _______ Date read _______ Results _______ Signature ______________________________
#2 Date given _______ Date read _______ Results _______ Signature ______________________________

Chest x-ray if one has had a previous positive skin test. (attach reports if applicable)

Signature of Physician / Nurse Practitioner: ______________________________ Date: __________________________ and stamp.
PERSONAL HEALTH HISTORY

To The Student: You must complete and bring this form with you on your first day of class.

Identification Data: Fill in the following information. Please print.

Name:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Initial</th>
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Address:

<table>
<thead>
<tr>
<th>Street Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Date of Birth: ____________________________

Emergency contact: ___________________________/ ____________________________

10 Panel Drug Screen should be within the past three months. Instructor will obtain printed results from Quest Diagnostics.

Influenza vaccine: all students must provide proof of receipt of the annual influenza vaccine by November 1 unless late spring or summer class.

Any student who declines an annual influenza vaccine due to medical reasons will need to bring signed documentation from their provider explaining the medical contraindication. If a student has a religious reason why they cannot receive an annual influenza vaccine they will need to bring in a notarized letter (on the religious organization’s letterhead) from the minister that documents their religious belief against receiving the annual influenza vaccine (influenza season October 1-March 31).

HISTORY

Do you have any physical limitations ☐ Yes ☐ No

Specify:

Are contact lens worn? ☐ Yes ☐ No

Are glasses worn? ☐ Yes ☐ No

Have you ever experienced difficulty hearing? ☐ Yes ☐ No

Do you have a history of:

- Tuberculosis ☐ Yes ☐ No
- Infectious Mononucleosis ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Epilepsy ☐ Yes ☐ No
- Heart Disease ☐ Yes ☐ No
- Emotional/Mental Disorder ☐ Yes ☐ No

I certify that this information is true to the best of my knowledge.

____________________
Signature

____________________
Date