

**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**

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
<input type="checkbox"/>	<input type="checkbox"/>	Skin and Nails	<input type="checkbox"/>	<input type="checkbox"/>	Mouth & Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular
<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Ears	<input type="checkbox"/>	<input type="checkbox"/>	Thorax	<input type="checkbox"/>	<input type="checkbox"/>	Rectum	<input type="checkbox"/>	<input type="checkbox"/>	Mental Status
<input type="checkbox"/>	<input type="checkbox"/>	Nose & Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_  
*Last First Initial*

Address: \_\_\_\_\_  
*Street Address*

\_\_\_\_\_ / \_\_\_\_\_  
*City State Zip Code*

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**