



Sonoma & Mendocino Counties

AMERICAN RED CROSS-SONOMA & MENDOCINO COUNTIES CHAPTER
Nurse Assistant/Home Aide Training
PHYSICAL EXAMINATION FORM

Name Sex M F Birthdate

Address City State Zip Phone

Have you had a serious illness, injury or surgery? If so, describe:

TO BE COMPLETED BY EXAMINING PHYSICIAN/NURSE PRACTITIONER

1. Current complaints/disabilities pertinent to the student's education in Nurse Assistant or Home Health Aide Training Program:

2. Medications used: Prescription and over-the-counter (use back if necessary)

Table with 3 columns: NAME, INDICATION, FREQUENCY

3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases, etc.

4. Examination comments and findings:

REQUIRED TUBERCULOSIS SCREENING

P.P.D. (Within 6 months) Date Results Chest X-ray (If P.P.D. is positive) Date Results

RECOMMENED IMMUNIZATIONS: not required.

Please give dates and provide copy of immunization record or serological confirmation.

Diphtheria & Tetanus 1st 2nd 3rd Booster required every 10 years.
Polio (completed series) 1st 2nd 3rd Booster (year taken)
Rubeola 1st 2nd or documented physician diagnosis of serological immunity
Rubella Date given or serological confirmation of immunity

The above named has no communicable or disabling disease nor health condition that would create a hazard to himself, visitors, classmates or patients at this time. He/she is able to perform the physical activities required for the training.

Examiner name and signature: Date

Address: Phone:

I give permission to release a copy of this form to affiliating clinical facility.

Student signature Date:

ATTACH P.P.D. AND CHEST X-RAY RESULT FORMS