AMERICAN RED CROSS
Nurse Assistant/Home Health Aide
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:

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TO BE COMPLETED BY EXAMINING PHYSICAN/NURSE PRACTITIONER

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

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

NAME	INDICATION	FREQUENCY

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

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4. Examination comments and findings:

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REQUIRED TUBERCULOSIS SCREENING

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

RECOMMENDED 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