BRING THIS PAGE TO: PHYSICAL / IMMUNIZATION / TITER TEST / DRUG TEST / LAB APPOINTMENT(s)

HEALTH RECORD

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**	**MARITAL SATUS** SINGLE DIVORCED MARRIED NO CHILDREN
ADDRESS *(STREET, CITY, ZIP)*			
TELEPHONE	**WHAT ARE YOU STUDYING TO BE?** *(SELECT ALL THAT APPLY)* ☐ Certified Nurse Assistant ☐ Home Health Aide		
NAME AND ADDRESS OF FAMILY DOCTOR/CLINIC			**STUDENT ID NUMBER**
DATE OF BIRTH	**LAST HIGH SCHOOL ATTENDED** *(NAME, CITY, STATE)*		

UNDERLINE DISEASE(S) YOU HAVE HAD

ANEMIA, ASTHMA, APPENDICITIS, BLACKOUTS, BRONCHITIS, CHICKEN POX, DIABETES, DIPTHERIA, EPILEPSY, HAY FEVER, EAR PROBLEM, HEART TROUBLE, JAUNDICE, KIDNEY PROBLEM, LARYNGITIS, MUMPS, MEASLES, NERVOUS BREAKDOWN, PLEURISY, PNEUMONIA, POLIO, RHEUMATIC, RHEUMATIC FEVER, SCARLET FEVER, SMALL POX, SICKLE CELL, SINUSITIS, TONSILITIS, TYPHOID FEVER, THYROID DISORDER, TUBERCULOSIS, ULCER, VARICOSE VEINS, WHOOPING COUGH

FAMILY HISTORY *(UNDERLINE and NOTE RELATIVE)*

TUBERCULOSIS
NERVOUS BREAKDOWN
DIABETES
CANCER

WHAT VACCINATIONS OR TESTS HAVE YOU HAD? WHAT YEARS?

☐ SMALL POX_____ ☐ TETANUS_____ ☐ CHEST X-RAY_____ ☐ POLIO_____

SERIOUS ILLNESSES:

_____

_____

OPERATIONS:

_____

_____

LIST YOUR MAJOR INJURIES:

_____

_____

ALLERGIES:

_____

_____

^^^^^ ***Section above must be completed by applicant.*** ^^^^^ *A complete physical examination including labs is required every two (2) years unless otherwise specified by affiliating hospital contracts.*

PHYSICAL EXAM: **DATE:** _____			ADDITIONAL DATA – SUMMARY - RECOMMENDATIONS
GENERAL APPEARANCE:	HEIGHT	WEIGHT	
POSTURE			
SKIN:	BACK:		
EYES: PERLA:	RETINA:		
EARS: R L	HEARING:		
NOSE AND THROAT:			
TEETH: GUMS: DENTAL HYGIENE			☐ **FREE OF COMMUNICABLE DISEASES – DOES NOT CREATE HAZARD TO SELF OR OTHERS**
GLANDS: THYROID			☐ **APPROVED AND RECOMMENDED FOR NURSING PROGRAM**
LUNGS:			☐ NOT APPROVED – SEE ABOVE
HEART:			☐ APPROVED PENDING AS ABOVE
PULSE:			**EXAMINED BY:** , MD
ABDOMEN:			NURSE PRACTITIONER
ENDOCRINE SYSTEM:			**LICENSE NO:**
NERVOUS SYSTEM:			**ADDRESS & PHONE NO.**
BLOOD PRESSURE:			

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HEALTH **RECORD**

STUDENT'S NAME (Print): _____ **STUDENT ID #:** _____

^^^^^ ***Section above must be completed by applicant.*** ^^^^^

*(*Required for NA Program)*	Date*(s)*	Results	**Dr. Signature/Address/Phone Number**
***Tuberculin Skin Test**			
OR			
Quantiferon Gold TB Test			
OR			
Chest X-ray			
***Hepatitis B**			
(Titer/Vaccine)			
***Measles**			
(Titer/Vaccine)			
***Mumps**			
(Titer/Vaccine)			
***Rubella**			
(Titer/Vaccine)			
***Polio**			
(Titer/Vaccine)			
If not applicable, write N/A with explanation for clearance			
***Varicella (Chicken Pox)**			
(Titer/Vaccine)			
***Diphtheria/Tetanus** *(Series of two, one month apart. Boosters in one year, then repeat in ten years. If you had series as a child, then all you need is the booster).*			
***Drug Screen**			
(8-panel minimum, with Lab Results)			
***Flu Vaccine** *(or Declination Form)*			

***COVID-19 vaccinations and boosters are required by healthcare facilities where clinical training takes place. Include record.**

IF THE TITER IS NEGATIVE OR DOES NOT SHOW IMMUNITY, SUBMIT A RECORD OF RECEIVING THE VACCINATIONS. THEN, A REPEAT TITER AS DESIGNATED PER MEDICAL PROTOCOL.
COPIES OF ALL LABORATORY REPORTS ARE REQUIRED (i.e. Drug Test and/or Titers).

Document subject to updates and modification - Updated: 05/25/2022