

**AMERICAN RED CROSS OF GREATER LONG BEACH  
NURSE ASSISTANT TRAINING/HOME HEALTH AIDE TRAINING  
PHYSICAL EXAMINATION FORM**

**OFFICE MUST INCLUDE FACILITY STAMP ON BOTH PORTIONS OF THIS FORM**

Name \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**TO BE COMPLETED BY EXAMINING PHYSICIAN/NURSE PRACTITIONER  
PLEASE COMPLETE ALL SECTIONS**

1. Current complaints or disabilities pertinent to the student's education in the Nurses Assistant or Home Health Aide Training Programs.
- \_\_\_\_\_
- \_\_\_\_\_

2. Medication used: Prescription and over the counter (Use back if necessary)

| Name  | Reason | Frequency |
|-------|--------|-----------|
| _____ | _____  | _____     |
| _____ | _____  | _____     |

3. Significant medical history: Major illness, accidents, deformities, surgeries, back problems, hepatitis, etc.
- \_\_\_\_\_

4. Examination Comments and Findings:
- \_\_\_\_\_

Normal Physical, patient able to participate in class physical activities. **(Circle one)** YES NO

**RECOMMENDED IMMUNIZATION [NOT REQUIRED]**

Please give Date: Must provide immunization record (copy is acceptable and/or copy of serological confirmation).

Diphtheria & Tetanus 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ Booster required every 10yrs

Polio: Completed series 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ Year given \_\_\_\_\_ Booster \_\_\_\_\_

Rubeola: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ or documented physician diagnosis

Rubella: Date given \_\_\_\_\_ or Serological confirmation of immunity

The above named has no communicable, disabling disease or any health condition that would create a hazard to himself fellow employees, visitors or to patients at this time. He/She is able to perform the physical activities required for the program for which the individual is applying.

Medical Examiner: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Physical (M.D.), or Physical's Assistant signature

Student Signature \_\_\_\_\_

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

**Facility Stamp**

.....  
**Name of Student:** \_\_\_\_\_

**Facility Stamp**

Required Screening for Tuberculosis **(Within 6 months of class)**

PPD (Attach Report Form) Date given \_\_\_\_\_ Date read \_\_\_\_\_

Chest x-ray [only if P.P.D. is positive] Date \_\_\_\_\_ Results \_\_\_\_\_

**DOCTOR REPORT MUST ACCOMPANY ALL CHEST X-RAY RESULTS.**