## CERTIFIED NURSING ASSISTANT PROGRAM
## PHYSICAL EXAMINATION FORM

**Student Name (PRINT):**________________________________ **Student ID#:** ______________________

**Address:** ________________________________________________________________________________

**Phone #:**________________________________ **Date of Birth:** ________________________________

**Instructions to Applicant:** **Complete the Health History Profile (below). Schedule an appointment with your health provider or Compton College's Student Health Center for a physical examination, required laboratory tests and immunization update. Take this form to your scheduled appointment. Have your health professional complete the Physical Exam, Laboratory and Immunization Report on page 2. Complete all sections of this form. Submit form to the CastleBranch databank website with copies of proof of immunizations and/or titers.**

**Have you had or have you ever been treated for any of the following conditions. Explain all yes answers**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **Hearing Problem** | | | **Are you taking any medication?**<br>If yes, please list all medications: | | |
| **Wear Glasses (Contacts)** | | | | | |
| **Dental Problems** | | | | | |
| **High Blood Pressure** | | | | | |
| **Heart Murmur** | | | | | |
| **Ulcer** | | | **Have you had any operations?**<br>If yes, please provide surgical history: | | |
| **Nervous Stomach** | | | | | |
| **Gall Bladder Disease** | | | | | |
| **Hemorrhoids** | | | | | |
| **Hernia** | | | | | |
| **Kidney/Bladder Infection** | | | | | |
| **Kidney Stones** | | | **Have you had any injuries in the past that limits your mobility or activities (e.g. back, head, etc.)?**<br>If yes, please describe your allergies and how they are treated: | | |
| **Mononucleosis** | | | | | |
| **Frequent Sore Throat** | | | | | |
| **Appendicitis** | | | | | |
| **Diabetes** | | | | | |
| **Hepatitis** | | | **Do you have any allergies?**<br>If yes, please describe your allergies and how they are treated: | | |
| **Epilepsy** | | | | | |
| **Frequent Respiratory Infection** | | | | | |
| **Asthma** | | | **Have you ever been treated for psychological problems?** If yes, please describe: | | |
| **Anemia** | | | | | |
| **Tuberculosis** | | | | | |
| **Tumors** | | | | | |
| **Skin Problems** | | | | | |
| **Psychological Problems** | | | | | |
| **HIV/AIDS** | | | **My signature below indicates that all information, provided is true and accurate to the best of my knowledge.** | | |
| **Rubeola (10 day Measles)** | | | | | |
| **Rubella (3 day German Measles)** | | | | | |
| **Mumps** | | | | | |
| **Chicken Pox** | | | ______________________________/______________ | | |
| Revised 2-24-15; Updated 5-2-16 | | | **Student Signature** **Date** | | |

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**Student Name (PRINT):**___________________________________ **Student ID#:** _______________________

Ht:________Wt:________Pulse:_________B/P:__________Hemoglobin:_________Urinalysis: ___________

| Eyes: | Ear: | Throat: |
|---|---|---|
| Teeth: | Gums: | Neck: |
| Chest: | Heart: | Lungs: |
| Abdomen: | Inguinal Rings: | Neurological: |
| Skin: | Genitourinary: | Back: |
| Extremities: | Pelvic (optional) | |

☐ **Student is negative for signs and symptoms of TB.** ☐ **Student is pregnant. EDC:** _____________

**PHYSICAL REQUIREMENTS –** the student must demonstrate a high degree of manual dexterity and physical flexibility and have the ability to perform repetitive tasks. The student should also have the ability to:

-walk the equivalent of five miles per day
- hear tape recorded transcriptions
- stand for long periods of time
- work with chemicals and detergents
- tolerate exposure to dust and/or fumes
- bend both knees
- sit for periods of time
- distinguish colors
- squat
- perform CPR
- reach above the shoulder level
- climb stairs or ladder
- adapt to shift work
- lift 25 pounds
- grip

**Activity Rating:** ☐ **No limitations** ☐ **Limitations** **Comments:** _______________________________
______________________________________________________________________________________

**Signature:**______________________________________________________ **Date:** ______________
**(Physician, Nurse Practitioner, or Physician Assistant)**

**AFFIX OFFICIAL FACILITY STAMP BELOW**
**Should include facility name, address, and phone number**

| **Tdap** (Tetanus, Diphtheria, Pertussis) vaccine documentation within the last 5 years | | **Vaccine Name:** | **Date of Vaccine** |
|---|---|---|---|
| **Hepatitis B Vaccine** | **1st Dose Date:** | **2nd Dose Date:** | **3rd Dose Date** |
| **COVID-19 Vaccine** | **1st Dose Date** | **2nd Dose Date:** | **Vaccine Name:** |

**Note:** Laboratory evidence of Surface Antibody for Hepatitis B (Anti-HBs or HBs AB) is required. **Laboratory evidence of IgG Immunity levels for**: Rubeola (10 day measles), Rubella (3 day German measles); Mumps, Varicella (Chickenpox) is required. The word "Immune" on a lab slip is **NOT accepted** by some hospitals.

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**Student Name (PRINT):** ______________________________________________________ ____________________

**Results of your QuantiFERON -TB Gold Blood Test Lab Results: Date:_______________ Result:_______________ (Positive or Negative)**

**<u>Tuberculosis Clearance</u>**

**Documentation of a negative <u>two step PPD</u> or Chest X-Ray (CXR) is required on admission to the program. The first two <u>step PPD</u> is placed and read in 48 – 72 hours. If the PPD is negative you should return for the <u>Second two step PPD</u> should be obtained <u>7-21 days after the first PPD and read</u> 48-72 hours later. If the <u>PPD is positive</u> a CXR is required. You must be asymptomatic & the CXR must indicate no active disease. If the PPD is negative. An annual PPD or CXR (for + PPD's) is required thereafter.**

**Right Arm** **Left Arm**

**Initials**_________ **Initials**

**Date** _________ **Date** _________

Place an X on the arm above at the site where the PPD injection was administered.

| | | |
|---|---|---|
| **First Two Step PPD # 1**<br>Date Administered:<br>____________________<br>Date Read: ___________ | Manufacturer<br>Lot #<br>Expiration Date: _____________ | Results _______mm<br>Initial's ____________<br>Signature:____________ |
| **Second Two Step PPD # 2**<br>Date Administered:<br>____________________<br>Date Read: ___________ | Manufacturer<br>Lot #<br>Expiration Date:_____________ | Results _______mm<br>Initial's ____________<br>Signature:____________ |
| **Annual PPD**<br>Date Administered:<br>____________________<br>Date Read: ___________ | Manufacturer<br>Lot #<br>Expiration Date: _____________ | Results _______mm<br>Initial's ____________<br>Signature:____________ |
| | **POSITIVE PPD** | |
| **Positive PPD**<br>Please specify the treatment regimen used for Positive PPD (*please check the appropriate box and indicated duration of treatment*) | ☐ **Isoniazid** (INH) _____________<br>☐ **Rifampin** ________________<br>☐ **Isoniazid (INH) & Rifapentine (RPT) Regimen**_______________<br>☐ **Other** ______________________ | ☐ Received BCG vaccine during childhood. |
| **Chest X-ray**<br>A copy of the CXR report must be submitted with physical examination. | Date: _____________<br>Results: ____________________ | Print Name:<br>______________________<br>Signature:<br>______________________ |