**HELLEN SCHOOL FOR CNA. Address 2047 Orange Ave, Long Beach CA 90806.Phone: (562)-241-4001**

**PHYSICAL EXAMINATION FORM (Office must include facility stamp on both portions of this form)**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_ M\_\_\_\_\_\_\_F\_\_\_\_Birthday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number of Patient :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Nurse Assistant or and Home Health Aid Training Programs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medication Name Reason to use it Frequency

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

4. Examination Comments and Findings : Done by Doctor or Physician Assistant.

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

Statement : 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 Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City /State/ Zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Stamp

Signature of Physician (M.D) or Physical’s Assistant Signature

Statement of Student and Signature :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I gave permission to release a copy of this form to affiliating

clinical or school Facility.

Name of Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Stamp

Required Screening for Tuberculosis ( within 6 months of class )

PPD (Attach Report Form) Date Given\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_=

 Date Read\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PPD results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If PPD is positive a chest X-ray is required. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor report must Accompany All CHEST X-Ray results.

\* Walk in at Address:19301 Santa Fe Ste 120 Rancho Dominguez. Ph # (310) 631- 5655 Douglas Industrial