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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY STUDENT** | | | | | | | | | | | | | | **STUDENT ID#:** | | | | | |
| **LAST NAME:** | | | | | **FIRST NAME:** | | | | | | | | | | | | **MI:** | | |
| **ADDRESS:** | | | | | | | | | | | | | **PHONE** (\_\_\_) \_\_\_ - \_\_\_\_ 🞏CELL 🞏HOME | | | | | | |
| **CITY:** | | | | **STATE**: | | | | | | | | | | | | **ZIP CODE:** | | | |
| **BIRTHDATE**: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | | | **AGE**: | | | | | | | **SEX**: | | | | | **HEIGHT**: | | | | **WEIGHT**: |
| **TO BE COMPLETED BY HEALTH CARE PROVIDER** | | | | | | | | | | | | | | | | | | | |
| **BLOOD PRESSURE:** | | | | | | | | | **PULSE RATE:** | | | | | | | | | | |
| **SIGNIFICANT MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | |
| **TB PPD 2 STEP TEST** | | **DATE READ:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | | | | | | | | | | **RESULT:** 🞏 NEGATIVE 🞏 POSITIVE (POSITIVE TEST REQUIRES CLEAR CHEST X-RAY) | | | | | | | |
| **INFLUENZA VACCINATION (for current flu season)** | | | | | | | | | | | | **DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | | | | | | | |
| **HEPATITIS B TEST** | **DATE OF TEST:**  \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | | | | | **RESULT:** 🞏 NEGATIVE 🞏 POSITIVE  If Negative, Vaccination Dates:  1)\_\_\_\_\_\_\_\_\_\_\_\_ 2)\_\_\_\_\_\_\_\_\_\_\_\_ 3)\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **CURRENT COMPLAINTS OF DISABILITIES PERTINENT TO STUDENT’S PARTICIPATION** | | | | | | | | | | | | | | | | | | | |
| **EXAMINATION (SYSTEM REVIEW)** | | | **NORMAL** | | | | | **ABNORMAL** | | | **COMMENTS** | | | | | | | | |
| 1. GENERAL APPEARANCE | | |  | | | | |  | | |  | | | | | | | | |
| 1. EYES | | |  | | | | |  | | |  | | | | | | | | |
| 1. EARS, NOSE & THROAT | | |  | | | | |  | | |  | | | | | | | | |
| 1. MOUTH & TEETH | | |  | | | | |  | | |  | | | | | | | | |
| 1. NECK | | |  | | | | |  | | |  | | | | | | | | |
| 1. LYMPH NODES | | |  | | | | |  | | |  | | | | | | | | |
| 1. RESPIRATORY | | |  | | | | |  | | |  | | | | | | | | |
| 1. CARDIOVASCULAR | | |  | | | | |  | | |  | | | | | | | | |
| 1. ABDOMEN | | |  | | | | |  | | |  | | | | | | | | |
| 1. SKIN | | |  | | | | |  | | |  | | | | | | | | |
| 1. NEURO | | |  | | | | |  | | |  | | | | | | | | |
| 1. MUSCULOSKELETAL | | |  | | | | |  | | |  | | | | | | | | |
| **RECOMMENDATIONS REGARDING PARTICIPATION IN THE NURSE ASSISTANT PROGRAM AND/OR HOME HEALTH AIDE** | | | | | | | | | | | | | | | | | | | |
| 🞏 CAN PARTICIPATE WITH NO RESTRICTIONS | | | | | | | 🞏 NO PARTICIPATION UNTIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | 🞏 NO PARTICIPATION | |

\*THE HEALTH CARE PROVIDER VERIFIES THAT THE INDIVIDUAL DOES NOT HAVE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD FOR HIMSELF/HERSELF, FELLOW EMPLOYEES, PATIENTS, AND VISITORS.

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| **HEALTH CARE PROVIDERS NAME: PLEASE REVIEW AND SIGN “HEALTH HISTORY”** | | | | |
| HEALTH CARE PROVIDER’S SIGNATURE: | | DATE: | | |
| HEALTH CARE PROVIDER’S NAME (PRINT): | | | | |
| ADDRESS: | CITY: | | STATE: | ZIP: |
| **I HEREBY AUTHORIZE RELEASE OF PERTINENT MEDICAL RECORD TO CONTRA COSTA COLLEGE NURSING DEPT.** | STUDENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_ | | | |