|  |  |
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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:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ |
| **Covid Vaccination: Manufacturer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date vaccine#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date vaccine #2\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **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: \_\_\_\_\_\_\_\_\_\_\_ |