

Best Care Medical Training Center

Nurse Aide Student Health Examination

Name: _____
 Date of Birth: _____ Sex: Male _____ Female _____
 Address: _____ City: _____ State: _____ Zip: _____

Applicant: Have you had or do you have any of the following?

| Yes | No | | Date | Surgery | Type |
|-----|-----|-------------------|-------|---------|------|
| () | () | Allergies | _____ | | |
| () | () | Asthma | _____ | | |
| () | () | Chronic Back Pain | _____ | | |
| () | () | Epilepsy | _____ | | |
| () | () | Diabetes | _____ | | |
| () | () | Headaches | _____ | | |
| () | () | Hearing problems | _____ | | |
| () | () | Chest pain | _____ | | |
| () | () | Hernia | _____ | | |
| () | () | Hypertension | _____ | | |
| () | () | Back Injuries | _____ | | |
| () | () | Rheumatic Fever | _____ | | |
| () | () | Other Injuries | _____ | | |
| () | () | Skin Disease | _____ | | |
| () | () | Tuberculosis | _____ | | |
| () | () | Other Illness | _____ | | |

State details for the items checked "Yes":

I certify that to my knowledge I have no injury, illness or ailment other than specifically noted and give the examining permission to submit a report to Best Care Health Agency.

Date: _____ Signature: _____



To be complete by Physician &/or Nurse Practitioner

1 – PPD: Date Administered: _____ Date Read: _____ Result: _____

2 - PPD: Date Administered: _____ Date Read: _____ Result: _____

(If # 1 PPD is negative, employee must have PPD # 2 within 1 – 3 weeks.)

(If # 1 PPD is positive, employee must get a Chest X-Ray with follow-up. A chest X-ray report must be submitted to Best Care.)

Height: _____ Weight: _____ B/P: _____ T: _____ P: _____ R: _____

Physical Findings:

EENT

LUNGS

EXTREMITIES

HEART

ABDOMEN

GENERAL OBSERVATIONS

I have no indication of any condition, which may represent a possible hazard to the health of the patient or other employees.

Date: _____ Examiner's Name: _____

Examiner's Signature: _____ Phone #: () _____

Address: _____

City: _____ State: _____ Zip: _____

