

Best Care Medical Training Center

Home Health 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: _____

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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.)

MMR: Date: _____
 (If born in 1957 or after)
 Rubella Titer Date: _____ Immune _____
 Rubella Titer Date: _____ Immune _____
 Hepatitis: Yes () No ()

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

Physical Findings:

EENT	HEART
LUNGS	ABDOMEN
EXTREMITIES	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: _____