HEALTH CAREERS / CVCC
PHYSICAL EXAMINATION RECORD
CONFIDENTIAL

EXAM COMPLETED AFTER MAY 12, 2022

DATE: _____

SUBMIT FORM TO HEALTH CAREERS INSTRUCTOR BY SEPTEMBER 16, 2022

LAST NAME	FIRST NAME	MIDDLE	D.O.B.	SEX

STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

REQUIRED BY CLINICAL LEARNING SITES:

TB Testing – Completed any time after May 12, 2022

2 Step PPD – Mantoux

Step 1: _____ Date _____ Result _____ Comment

Step 2: _____ Date _____ Result _____ Comment

OR If you have had a 2-Step Mantoux within the last year, only a TBC booster is required. _____ Date

If you have had or have a positive Mantoux Skin Test, we will require a chest x-ray showing no active disease process.

Hepatitis B Vaccinations (series of three with dates)

#1 _____ Date #2 _____ Date #3 _____ Date

OR Positive Titer (date and results) _____ Date _____ Result

OR Waiver signed and returned to the school.

MMR Vaccination

_____ Date

OR Positive Titer (date and results) _____ Date _____ Result

Tetanus – Diphtheria (DT) Toxoid Booster

Within the last 10 years _____ **Date**

Varicella (Chicken Pox) - Those with no prior history of Chicken Pox, require 2 varicella vaccines. (list dates) #1 _____ Date #2 _____ Date

OR Positive Titer (date and results) _____ Date _____ Result

COVID Vaccination

_____ Type #1 _____ Date #2 _____ Date

All immunizations are current for candidate's age: YES _____ NO _____

Exclusions may include those with life threatening allergies, pregnant, and/or immune suppressed.

Explain any deferred or missing immunizations: _____

Mark Appropriate Space:

	YES	NO		YES	NO		YES	NO
Allergies			GI Disturbances			Nervousness		
Asthma			Heart Disease			Seizure Disorder		
Backaches			High Blood Pressure			Shortness of Breath		
Chronic cough			Infected Sinuses			Swollen/painful joints		
Frequent sore throat/colds			Kidney Infections/Stones			Varicose Veins		
Frequent headaches			Liver Disease			Venereal disease		

Health History, Medical Problems, Previous Operations: _____

_____

Previous Serious Illness: _____

HEIGHT _____ **WEIGHT** _____ **TEMPERATURE** _____ **PULSE** _____ **RESPIRATION** _____ **BLOOD PRESSURE** ____/____

NORMAL	ABNORMAL	EXPLANATION OF FINDINGS
		ABDOMEN
		ENT
		EXTREMITIES
		EYES
		HEART
		LUNGS
		MUSCULO-SKELETAL
		PERIPHERAL VASCULAR
		SKIN
		SPINE (CURVATURE)
		THYROID

Currently receiving therapy or medications? YES _____ NO __

Specify: _____

Has person been treated for any nervous disorder or emotional stress? YES _____ NO __

Current treatment/medication: _____

This individual's health status qualifies them to work directly with patients as a student Nursing Assistant

YES _____ NO _____

_____ _____ _____

Physician Signature **Phone Number** **Date**

I certify that the information on this record is accurate and complete. I understand if I offer false, misleading or incomplete information, I may be subject to dismissal from the Health Careers Program at CVCC. **Additionally, you have my permission to call/contact the evaluating physician/organization regarding the accuracy and completeness of this physical examination record and submit same to clinical partners.**

Please make copies of all health records for your own file before submission to the school as no copies will be made for you at a later date.

_____

Student Name (Printed)

_____ _____ _____ _____

Student's Signature **Date** **Parent(s) and/or Guardian(s) Signature** **Date**