AMERICAN RED CROSS BAY AREA CHAPTER
Nurse Assistant Training
PHYSICAL AND TUBERCULOSIS EXAMINATION FORM

Name ____Sex M_____ F____ Birthdate_____________

Address _________________________ City___________ State____ Zip_______ Phone___________

Have you had a serious illness, injury or surgery? If so, describe:

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TO BE COMPLETED BY EXAMINING PHYSICAN/NURSE PRACTITIONER

1. Current complaints/disabilities pertinent to the student's education in Nurse Assistant:

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2. Medications used: Prescription and over-the-counter (use back if necessary)

NAME INDICATION FREQUENCY

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3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases, etc.

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4. Examination comments and findings:

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REQUIRED TUBERCULOSIS SCREENING

P.P.D. (Within 6 months)	Date	Results
Chest X-ray (If P.P.D. is positive)	Date	Results

RECOMMENED IMMUNIZATIONS: not required.
Please give dates and provide copy of immunization record or serological confirmation.

Diphtheria & Tetanus	1st______	2nd_______	3rd______	Booster required every 10 years.
Polio (completed series)	1st_______	2nd_______	3rd______	Booster (year taken)
Rubeola	1st_______	2nd_______	or documented physician diagnosis of serological immunity	
Rubella	Date given__________	or serological confirmation of immunity____________		

The above named has no communicable or disabling disease nor health condition that would create a hazard to himself, visitors, classmates or patients at this time. He/she is able to perform the physical activities required for the training.

Examiner name and signature:____Date___________
Address:____Phone:___________________________

I give permission to release a copy of this form to affiliating clinical facility.

Student signature ____ Date: ______________
ATTACH P.P.D. AND CHEST X-RAY RESULT FORMS

Email to: HSService@usa.redcross.org
Fax to: (415) 692-8211
Mail to: ARCBA 85 Second Street, 8th Floor,
San Francisco, CA 94105 Attn: Nurse Assistant Program