

Windward Community College

Employment Training Center and Continuing Education and Special Programs

PHYSICAL EXAMINATION

Name: Sex: M F Birth Date: Address: City: Zip: Home Phone: Work Phone: Cell/Pager: Have you had a serious illness, injury, or surgery? If so, describe:

TO BE COMPLETED BY EXAMINING PHYSICIAN/ NURSE PRACTITIONER

1. Current complaints or disabilities pertinent to the student's education in Nurse's Aide Training Program:

2. Medication used: Prescription and over-the-counter (use back if needed)

Table with 3 columns: Name, Reason, Frequency. Includes three rows of blank lines for data entry.

3. Significant medical history: Major illness, accidents, deformities, surgeries, back problem, hepatitis, etc.

4. Examination comments and findings:

REQUIRED SCREENING FOR TUBERCULOSIS
P.P.D (within 12 months) Date: Results:
Chest X-ray P.P.D. if positive (within 12 months) Date: Results:
ATTACH P.P.D & CHEST X-RAY RESULTS FORM(S)

The above named has no disabling disease nor any health conditions that would create a hazard to himself/herself, fellow employees, visitors, or to patients at this time. He/She is able to perform the physical activities required for the program for Nurse's Aide training.

Physician: Phone:

Address: City/State/Zip:

Physician's Signature: Date:

Physician (M.D.) or Physician's Assistant

Student's Signature: Date:

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