Center for Workforce & Community Education
Nurse Assistant /Home Health Aide Training Program
Health Care Provider's Examination

Name: _____

Date of Birth: _____

Pertinent Medical History

Current Health Issues

Y **N**

☐ ☐ Allergies: Please list: Medications _____ Food_____

Other _____

History of Anaphylaxis to _____ Epi-Pen® ☐ Yes ☐ No

☐ ☐ Asthma

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder_____

☐ ☐ Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety)

Physical Examination

Date of Examination: _____

Height: _____ (_____ %) Weight :_____(_____%) BMI: _____ (_____ %) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General_____ ☐ Lungs_____ ☐ Extremities_____

☐ Skin_____ ☐ Heart_____ ☐ Neurologic_____

☐ HEENT_____ ☐ Abdomen_____ ☐ Other_____

☐ Dental/Oral_____ ☐ Genitalia_____

Laboratory Results: ☐Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: ____; Results: ____mm. ☐ NEGATIVE ☐ POSITIVE

Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐Y ☐ N **Based on your evaluation, do you feel this person can meet the program requirements without doing harm to him/ herself.**

This student is capable of performing those activities required by enrollment in the NA/HHA Training Program.. If no, please list restrictions: _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____

Signature of Examiner DATE: Print name of Examiner

_____

Address State Phone

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: ____/____/____

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		**Measles, Mumps, Rubella** (MMR) **Varicella** (Var)	1	
	2			2	
	3			1	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) ***Td booster required every 10 years**	1			2	
	2		**Hepatitis A** (HepA)	1	
	3			2	
	4		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	5			2	

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

_____

Doctor or Nurse's Name (PLEASE PRINT)

_____

Signature **Date**