Vasco Career College

11299 San Pablo Ave., Suite V
El Cerrito, CA 94530
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www.vascocc.com

NURSING ASSISTANT TRAINING PROGRAM
History and Physical

TO BE COMPLETED BY STUDENT		
Student Name	Sex: M F	Birth Date:
Program:		
Have you had a serious illness, injury or surgery? Yes No	If yes, please describe:	

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER		
1. Current complaints or disabilities, including pregnancy, pertinent to the student's participation in training program:		
2. Medications used, prescription, and over-the-counter (use back if necessary):		
Name	Indication	Frequency
3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases, pregnancy:		
4. Examination comments and findings:		

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STUDENT SIGNATURE IS REQUIRED

I give permission to release a copy, pages 2 & 3 of this form to the affiliating facility, If necessary.

Signature _____ Date _____

Print Name _____

TO COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

Immunization	Documented Dates (attach documentation)		Initials	Comments
Required Tuberculosis Screening: (2-step TST)	Date	Result in millimeters		
Step One – (If positive, a CXR must be done)				
Step Two - (If 1st is negative, redo in 1 -3 weeks)	Date	Result in millimeters		
Blood Test (QFT-G, QFT-GIT,	Date	Result		
OR T-Spot) List test done:				
Chest X-Ray (if needed to confirm Positive TST)	Date	Result		
Hepatitis B Vaccine 1	Date	Result		
Hepatitis B Vaccine 2 – (4 weeks after 1st)	Date	Result		
Hepatitis B Vaccine 3 – (5 months after 2nd	Date	Result		
Flu Vaccine (Seasonal)	Date	Result		

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MEDICAL FINDINGS:				
Height: ft.	in. Weight:	lb.	Vital Signs: TPR	BP
Vision:				
Without GL (R) 20/.	(L) 20/			
With GL (R) 20/.	(L) 20/			
Hearing:		Heart:		
Eyes:		Lungs:		
Ears:		Abdomen:		
Nose:		Bones/Joints:		
Throat:		Varicose Veins:		
Teeth/Gums:		Feet:		
Lymph Nodes:		Posture:		
Thyroid:		Skin		
Breasts		Other:		
GENERAL CONDITION: Any restrictions on lifting/moving and why?				
I consider the applicant to be:				
( ) Well suited for admission to the program				
( ) Not suited for admission to the program				
I certify that the student does not have any health condition that would create a hazard to him/herself, fellow students, employees or patients.				
Physician Signature:		Date:		
Address:				