

| PHYSICAL EXAMINATION PHYSICIAN FORM | | | | | | |
|---|--------|-------------|----------|--------------------|-----------------|--|
| Last Name: | | First Name: | | | Middle Initial: | |
| System | NORMAL | ABNORMAL | COMMENTS | | | |
| General Health | | | | | | |
| Cardiovascular | | | | | | |
| Endocrine | | | | | | |
| Extremities | | | | | | |
| HEENT | | | | | | |
| Gastrointestinal | | | | | | |
| Neurologic | | | | | | |
| Respiratory | | | | | | |
| Reproductive | | | | | | |
| Skeletal | | | | | | |
| Skin | | | | | | |
| Urinary | | | | | | |
| B/P | Pulse | Resp | Temp | Weight | Height | |
| IMMUNIZATION DOCUMENTATION: Please attach copies of immunization records and print out of lab results* | | | | | | |
| REQUIRED IMMUNIZATION and LABS | | | DATE | RESULTS / COMMENTS | | |
| <input type="checkbox"/> Mumps Titer* | | | | | | |
| <input type="checkbox"/> Measles Titer* | | | | | | |
| <input type="checkbox"/> Rubella Titer* | | | | | | |
| <input type="checkbox"/> Varicella Titer* | | | | | | |
| <input type="checkbox"/> Tetanus Vaccine – dated within last 10 years | | | | | | |
| <input type="checkbox"/> Hepatitis B Vaccine Series* Dates of vaccination | | | | | | |
| <input type="checkbox"/> 1 st Shot | | | | | | |
| <input type="checkbox"/> 2 nd Shot | | | | | | |
| <input type="checkbox"/> 3 rd Shot | | | | | | |
| <u>Or</u> Date and result of Hepatitis B Vaccine Titer*. Students may be required to update, accept or receive additional vaccines if indicate necessary by titer’s results. | | | | | | |
| <input type="checkbox"/> TB Skin Test* | | | | | | |
| If TB skin test was positive was treatment received? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| If TB test was positive was chest x-ray done? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Flu Vaccine (as per seasonal requirements). Show document | | | | | | |
| Urine Drug Screen* 9 Panel (must complete through Viewpoint) | | | | | | |
| Does the student have any physical, medical or mental conditions that would impede their ability to provide safe and competent care of patients in a health care environment? <input type="checkbox"/> No <input type="checkbox"/> Yes (please comment below) Health Care Provider Comments: | | | | | | |
| Examining Health Care Provider: _____ Date: _____ | | | | | | |

Health Care Provider office / address contact information:

TECHNICAL PERFORMANCE STANDARDS

Students enrolled must demonstrate the ability to meet the following technical/performance standards while receiving classroom and clinical instruction as outlined in the course syllabus.

1. Read and communicate orally and in writing using the English language.
2. Hear with or without auditory aids to understand normal speaking voice without viewing the speaker's face.
3. Visually, with or without corrective lenses, observe changes in resident/patient/client's condition and actively participate in the learning process.
4. Utilize stamina, strength and psychomotor coordination necessary to perform routine nurse assistant/aide procedures at floor and bed level.
5. Demonstrate use of gross and fine motor skills necessary to provide independent, safe and effective nurse assistant/aide care.
6. Solve basic care problems and apply critical thinking skills while providing safe and efficient patient care.
7. Interact with individuals/families/groups from various socioeconomic and cultural backgrounds.
8. Function in a multi-stressor environment while adhering to legal/ethical guidelines of the college, program, regulatory, and clinical agencies.

Comments:

I attest this student can meet the technical/performance standards:

Examining Health Care Physician/Provider: _____ Date: _____

Signature required