



**Department of Nursing and Allied Health  
Nursing Assistant**

**PHYSICAL AND IMMUNIZATION FORM**

All areas are required to be completed for acceptance as a completed physical for the nursing assistant program.

**NURSING ASSISTANT STUDENT APPLICANT INFORMATION (to be completed by the student applicant):**

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Last Name	First Name	Middle Initial
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Home Address (Number and Street)	City/Town	State	Zip Code	Date of Birth
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Home Telephone Number	Alternate Telephone Number
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**IMMUNIZATION INFORMATION (to be completed by the physician):**

**To the examining physician:** Comment on all positive answers and indicate date of disease, immunization, or results of lab tests.

\***Mumps immunization:** must have been received after 1979 or immunity from disease confirmed by a physician.

\***Tetanus booster:** required documentation of this booster if immunization was not within the last ten years.

\***Tuberculosis testing:** TB test must be current. A baseline 2-step test is required for all students who have not had a previous 2-step. A one step test is required each year thereafter. A negative chest X-ray and yearly physician documentation of negative physical signs and symptoms of tuberculosis is required for any positive TB skin test.

DISEASE	DATE OF IMMUNIZATION			DATE OF DISEASE	LAB RESULTS/COMMENTS
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Measles					
*Mumps					
Rubella					
Polio					
*Tetanus-Diphtheria Booster					
*Tuberculosis testing					
Hepatitis					

**PHYSICAL INFORMATION (to be completed by the physician):**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Corrected Vision: Right 20/\_\_\_\_\_ Left 20/\_\_\_\_\_

Any abnormalities of the following areas?	YES	NO	IF YES, PLEASE EXPLAIN. (include current treatments)
Head, Ears, Nose, or Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Psychiatric			
Skin			
Lymph Nodes			

	YES	NO	IF YES, PLEASE EXPLAIN. (Attach additional sheets as necessary)
Is there loss or serious impaired function of any organ or limb?			
Is there any back impairment or lifting restrictions? (need to be able to individually lift a minimum of 50 lbs)			
Do you have any recommendations for any physical or emotional/psychological restrictions?			
Is there anything that may make it difficult for the student to participate physically or emotionally/psychologically in the nursing assistant program?			

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Last Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_