Renaissance Care Center Basic Nursing Assistant Physical Exam Form

Return by designated deadline: Renaissance Care Center 1675 East Ash Street Canton, IL 61520
Attn: Program Coordinator

Section 1 – Personal Information

Student completes this section.

Student Name (last, first, middle):_____

Street Address:_____ Phone Number:_____

City, State, Zip:_____ Date of Birth:_____

SWIC Student Email Address:_____ - _____@swic.edu

Emergency Contact:

Name:_____ Relationship: ☐ Spouse ☐ Parent ☐ Other:_____

Phone:_____

Section 2 – Medical History

Student completes this section. Medical examiner is encouraged to discuss with student.

Check all that apply – use the space below to provide details:

- ☐ Heart disease or heart attack
- ☐ Heart murmur or Arrhythmia
- ☐ Fainting/dizziness
- ☐ Diabetes (specify control method)
- ☐ Thyroid disease
- ☐ Eye disorder/vision loss
- ☐ Ear disorder/hearing loss
- ☐ GERD, Chron's disease, IBS, etc
- ☐ Any allergic reaction (drug, food, product, latex, etc)
- ☐ Skin disease
- ☐ Back injury, scoliosis or chronic lower back pain
- ☐ Arthritis
- ☐ Orthopedic disorder
- ☐ Mental disorder/emotional instability
- ☐ Head injury
- ☐ Stroke or paralysis
- ☐ Headaches/migraines
- ☐ Neurological disorder
- ☐ Seizure disorder/Epilepsy
- ☐ Depression
- ☐ Shortness of breath, asthma, cough or hoarseness
- ☐ Pulmonary disease
- ☐ Tuberculosis
- ☐ Cancer (specify type)
- ☐ Abnormal bleeding
- ☐ Major Surgery
- ☐ Other _____
- ☐ Other _____

Provide details from all boxes checked above (attach additional sheets if more room is needed):

_____

_____

_____

List any current medications or treatments (attach additional sheets if more room is needed):

_____

_____

_____

Section 3 – Physical Examination

Medical Examiner (MD, DO, ARNP or PA) completes this section.

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

System:	Normal	Abnormal/Surgery (explain - attach additional sheets if more room is needed)
Cardiovascular	☐	☐ _____
Endocrine/Metabolic	☐	☐ _____
Eyes/Ears/Nose/Throat	☐	☐ _____
Gastrointestinal	☐	☐ _____
Genitourinary	☐	☐ _____
Integumentary	☐	☐ _____
Musculoskeletal	☐	☐ _____
Neurological	☐	☐ _____
Respiratory	☐	☐ _____

Section 4 – Tests/Immunizations – ALL SECTIONS IN WHITE MUST BE COMPLETED

Medical Examiner completes this section.

A **Two Step Tuberculosis Screening: Step 1 Date:**_____ **results**_____**mm. Step 2 Date:**_____ **results**_____**mm.**
Attach chest x-ray if ANY result is positive. ___
Calmette-Guerin (BCG) vaccine Date: _____ **Quantiferon Gold results: Neg** ____ **Pos** _____ **T-Spot: Neg**_____ **Pos**_____

B **Influenza (Flu shot): Date**_____

C **Tdap date:** ___/___/_____ **Td booster date:** ___/___/_____
(Tetanus/Diphtheria & Pertussis) One time dose of Tdap required. **(Tetanus/Diphtheria)** After Tdap, Td booster within 10 years.

MMR Vaccine dose 1: ___/___/_____
MMR Vaccine dose 2: ___/___/_____
OR
Measles Titer: ___/___/_____ ☐ Yes ☐ No
Mumps Titer: ___/___/_____ ☐ Yes ☐ No
Rubella Titer: ___/___/_____ ☐ Yes ☐ No

E **Varicella (Chicken Pox):** Indicate disease **or** vaccine **or** titer.
☐ **Disease** was contracted. *(If box checked; MD signature below acts as confirmation.)* **or** ☐ **Vaccine:** Dose 1: ___/___/_____ Dose 2: ___/___/_____ **or** ☐ **Titer**: *(Attach lab results)* Immune: ☐ Yes ☐ No

F **Hepatitis B Vaccine Series: Waiver signed: Date**_____
1: ___/___/_____ (Dose 1) 2: ___/___/_____ (1 month after dose 1) 3: ___/___/_____ (5 months after dose 2) or ☐ **Titer**: *(Attach lab results)* Immune: ☐ Yes ☐ No

G COVID-19 Vaccine:	Product Name/Manufacturer:	Date:	
1st Dose		___/___/_____	
2nd Dose *(if applicable)*		___/___/_____	
Booster		___/___/_____	**Attach lab results**

Medical Examiner: Please complete

I verify that I have reviewed this completed form with the student. I consider this student:

☐ Mentally and physically able to undertake this program. ☐ Not mentally and physically able to undertake this program.

Signature: _____ Printed Name: _____

Date: _____

Office Name/Address/Phone: _____ (_____)_____-_____

Student: Read, Sign and Date

The information I have provided is complete and accurate to the best of my knowledge and I have attached all laboratory results. I understand that failure to complete this form correctly may jeopardize my participation in the clinical portion of this program.

Signature: _____ Printed Name: _____

Date: _____

Renaissance Care Center
Basic Nursing Assistant Training
Hepatitis B Vaccine Waiver

Student Name: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have received the Hepatitis B vaccine and have provided the dates on the Renaissance Care Center Basic Nursing Training Program Physical form OR have signed this waiver which is my declaration that I have been given the opportunity to receive the Hepatitis B vaccine and have declined. I do understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I decline the Hepatitis B vaccine.

Student Signature:_____

Date: _____