

# Renaissance Care Center Basic Nursing Assistant Physical Exam Form

Return by designated deadline: Renaissance Care Center 1675 East Ash St. Canton Illinois 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:*

- |  |  |
|--|--|
| <input type="checkbox"/> Heart disease or heart attack                           | <input type="checkbox"/> Head injury   |
| <input type="checkbox"/> Heart murmur or Arrhythmia                              | <input type="checkbox"/> Stroke or paralysis                                 |
| <input type="checkbox"/> Fainting/dizziness                                      | <input type="checkbox"/> Headaches/migraines                                 |
| <input type="checkbox"/> Diabetes (specify control method)                       | <input type="checkbox"/> Neurological disorder                               |
| <input type="checkbox"/> Thyroid disease   | <input type="checkbox"/> Seizure disorder/Epilepsy                           |
| <input type="checkbox"/> Eye disorder/vision loss                                | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Ear disorder/hearing loss                               | <input type="checkbox"/> Shortness of breath, asthma, cough or hoarseness    |
| <input type="checkbox"/> GERD, Chron's disease, IBS, etc                         | <input type="checkbox"/> Pulmonary disease                                   |
| <input type="checkbox"/> Any allergic reaction (drug, food, product, latex, etc) | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Skin disease  | <input type="checkbox"/> Cancer (specify type)                               |
| <input type="checkbox"/> Back injury, scoliosis or chronic lower back pain       | <input type="checkbox"/> Abnormal bleeding                                   |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Major Surgery                                       |
| <input type="checkbox"/> Orthopedic disorder                                     | <input type="checkbox"/> Adverse reactions to sensory stimulating activities |
| <input type="checkbox"/> Mental disorder/emotional instability                   | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine/Metabolic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes/Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Section 4 – Tests/Immunizations – ALL SECTIONS IN WHITE MUST BE COMPLETED***Medical Examiner completes this section.***A Two Step Tuberculosis Screening:** Attach chest x-ray if ANY result is positive.Step 1 date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results:  Neg  Pos | Step 2 date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results:  Neg  Pos**B Influenza (Flu shot):** Annual flu shot is REQUIRED**C Tdap date:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Td booster date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

(Tetanus/Diphtheria &amp; Pertussis) One time dose of Tdap required.

(Tetanus/Diphtheria) After Tdap, Td booster within 10 years.

**D Measles, Mumps and Rubella:***(Attach lab results for all titers)*

Immune:

MMR Vaccine dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_

Measles Titer: \_\_\_\_/\_\_\_\_/\_\_\_\_

 Yes  No

MMR Vaccine dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_

**OR**

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:**

Immune:

1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Dose 1)2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(1 month after dose 1)3: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(5 months after dose 2) **Titer:**  
*(Attach lab results)*  
 Yes  No**G COVID-19 Vaccine:****Product Name/Manufacturer:****Date:**1<sup>st</sup> Dose2<sup>nd</sup> 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: \_\_\_\_\_