Chariho Adult Education
Nursing Assistant Training Program
Medical Immunizations/Physical Form

Please Print Clearly

Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone: (___)_____ Cell: (___)_____

Physical Exam

Based on this examination, does this student have any communicable diseases?_____

_____

In your opinion, are there any conditions preventing this student from attending clinical classes as a nursing assistant?_____

_____

Immunizations

MMR: Proof of Immunization – Verified dates of immunization or titers are acceptable.
(Student must have documented proof of immunity)

Measles:_____ History of Varicella: Date_____
Mumps:_____ or titer and result:_____
Rubella:_____ or vaccination:_____

Date of most recent Flu vaccination:_____

Two-step PPD #1 Date placed:_____ #2 Date placed:_____
Date read:_____ Date read:_____
Results:_____mm Results:_____mm

Date of last Tetanus:_____ **Date of Tdap** (if administered)_____
(If greater than two (2) years since last Td ***MUST*** have a Tdap administered prior to clinical)

Primary Care Provider(***Please print name***):_____

Signature PCP:_____ Date:_____