HAPPY HANDS HEALTHCARE CNA SCHOOL

10557 Magnolia Avenue, Riverside, CA 92505 | (951) 977-8122
STUDENT ADMISSION PHYSICAL EXAMINATION & CLINICAL CLEARANCE

Student name: _____ **Date of birth:** _____

Program: [ ] CNA [ ] HHA **Class start date:** _____ **Exam date:** _____

Provider instructions: Complete the medical history review and examination, assess the listed training activities, and sign the clearance. Identify functional restrictions or recommended accommodations without listing diagnoses unless necessary. Clinical activities must follow safe patient-handling practices and facility policy.

1. MEDICAL HISTORY & VITAL SIGNS

Medical history reviewed: [ ] Yes [ ] No Relevant functional concerns / follow-up: _____

_____

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____ Respirations: _____ Temperature: _____

Vision (with correction if used): _____ Hearing (with aids if used): _____

2. PHYSICAL EXAMINATION — PROVIDER TO COMPLETE

Body system / examination	Normal	Abnormal	Not assessed / comments
General appearance / constitutional	[ ]	[ ]	_____
Head, eyes, ears, nose and throat	[ ]	[ ]	_____
Neck / lymphatic	[ ]	[ ]	_____
Cardiovascular / heart	[ ]	[ ]	_____
Respiratory / lungs	[ ]	[ ]	_____
Abdomen / gastrointestinal	[ ]	[ ]	_____
Musculoskeletal / back / joints	[ ]	[ ]	_____
Extremities / strength / range of motion	[ ]	[ ]	_____
Neurologic / balance / coordination	[ ]	[ ]	_____
Skin / integrity	[ ]	[ ]	_____
Other examination as clinically indicated	[ ]	[ ]	_____

Examination comments / follow-up: _____

_____

3. FUNCTIONAL ABILITIES FOR CNA / HHA TRAINING

Check one per activity. Assess with usual assistive devices or reasonable accommodations where applicable. Do not test unsafe patient lifting.

Activity	Able	With accommodation	Unable / assess further
Stand and walk for extended clinical periods	[ ]	[ ]	[ ]
Bend, stoop, squat, kneel and reach	[ ]	[ ]	[ ]
Lift and carry up to 35 lb of supplies/equipment	[ ]	[ ]	[ ]

Activity	Able	With accommodation	Unable / assess further
Push and pull occupied wheelchairs, beds or equipment using safe techniques	[ ]	[ ]	[ ]
Assist with turning, repositioning and transfers using required staff/equipment	[ ]	[ ]	[ ]
Use both hands for grasping, fine motor tasks and personal care	[ ]	[ ]	[ ]
See, hear and communicate sufficiently for safe patient care, with aids if used	[ ]	[ ]	[ ]
Maintain balance and respond to patient-care needs	[ ]	[ ]	[ ]

Specific limits, duration, equipment, accommodations, or reassessment date: _____

_____

4. TUBERCULOSIS SCREENING / FOLLOW-UP

TB screening reviewed: [ ] Yes [ ] Pending [ ] Separate documentation attached

Method / date / result: _____

If positive or medically contraindicated, document appropriate clinical evaluation and chest X-ray status as indicated: _____

_____

5. PROVIDER'S CLINICAL CLEARANCE

Based on the medical history, examination, and functional assessment, select one:

[ ] Cleared for classroom and supervised clinical participation without identified restrictions.

[ ] Cleared with the restrictions / accommodations described above; school and clinical site to review implementation.

[ ] Further evaluation required before clinical participation. [ ] Not cleared at this time.

I have assessed whether the student has a health condition that would create a hazard to the student, other staff/students, or patients: [ ] No identified hazard [ ] Further evaluation / precautions needed.

Additional comments: _____

_____

Provider printed name / credentials: _____

Provider signature: _____ **Date:** _____

Clinic name: _____ **Phone:** _____

Clinic address: _____

School use only: Form received _____ Reviewed by _____ Clinical clearance verified _____. TB and any clinical-site requirements must be verified separately when documentation is pending.