**SIVAM HEALTHCARE TRAINING INC.**

**1120 South Orange Avenue, Newark, NJ 07106**

**Telephone: (973)-373-9080**

**Fax: (973)-373-9081**

**E-mail:**sivam.healthcare.training@gmail.com

**HOME HEALTH AIDE STUDENT HEALTH EXAMINATION FORM**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male\_\_\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant: Have you had, or do you have any of the following?**

**Yes No Date Surgery Type**

**( ) ( ) Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Chronic Back Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Epilepsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Diabetes Mellitus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Headaches \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Hearing problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Chest Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Back Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Rheumatic Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Other Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Skin Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Tuberculosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) ( ) Other Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State details for the items checked “Yes”:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++**

**To be completed by Physician &/or Nurse Practitioner**

**Tests/Lab results (2 Step PPD- NJ State requirements.**

#1-PPD: Date Administered:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2- PPD: date Administered:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Read:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If #1 PPD is negative, applicant must have PPD #2 within 1-3 weeks.)

If PPD is positive, applicants must get a Chest X-ray with follow-up. A chest x-ray report must be submitted to Sivam Healthcare training Inc.

MMR: Date:\_\_\_\_\_\_\_\_\_ (If born in 1957 or after).

Rubella Titer Date:\_\_\_\_\_\_\_\_\_\_ Immune:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles Titer Date: \_\_\_\_\_\_\_\_\_\_Immune:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis: Yes ( ) No ( )

Mumps Titer Date: \_\_\_\_\_\_\_\_\_\_\_Immune:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_ B/P:\_\_\_\_\_\_\_\_\_\_\_\_ T:\_\_\_\_\_\_\_\_\_ P:\_\_\_\_\_\_\_\_\_\_\_\_ R\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL FINDINGS:**

**EENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEART:\_\_\_\_\_\_\_\_ ABDOMEN:\_\_\_\_\_\_\_\_\_\_ EXTREMITIES:\_\_\_\_\_\_**

**EXTREMITIES:\_\_\_\_\_\_\_\_\_\_ GENERAL OBSERVATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have no medical condition which may be of risk to self and others**

**Examiner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Examiner’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: ( )\_\_**