Nursing Assistant Program Physical Assessment Form

NAME:

____

ADDRESS:____

CITY:____**ZIP CODE:** ______________

TELEPHONE NUMBER: ___________________ **NAME OF THE SCHOOL:** _________________

Date of Birth: _________/__________/___________

ANSWER THE FOLLOWING QUESTIONS. PLEASE BE HONEST

EXPLAIN ANY QUESTIONS ANSWERED WITH A YES.

ALLERGIES: Yes: __________***No:***____________

Please list any allergies here:____

____

Do you have any Mental Disorders or Mental Health concerns? YES: ______***NO:***______

If Yes, Please Explain. This will not disqualify you from the program and will be confidential.

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HEARING PROBLEMS: YES:__________***NO:***____________

BACK PROBLEMS: YES:__________***NO:***_____________

LIFTING RESTRICTIONS: YES: _________***NO:***_____________

(i.e., arthritis, injury, surgeries etc.) If so, please provide a letter of release signed by a physician giving you permission to participate in the program.

Are you Allergic to Latex; YES: _________**NO:** _________

If so, what signs and symptoms do you display after exposure to Latex.

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Please list any other conditions that you feel may present a risk for you or that the instructor should be aware of to protect you.

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SIGNATURE: ____

PRINT NAME:____

DATE: ________________________

EMERGENCY CONTACT INFORMATION:

Contact Name: ____

Contact Telephone # ____

Relation to Contact Person: ____