Vasco Career College
NURSING ASSISTANT TRAINING PROGRAM
Vasco Career College *11155 San Pablo Ave Ste A * El Cerrito, CA 94530
Phone: 510-243-7400, Fax: 510-243-7411 8 www.vascocc.com

History and Physical

TO BE COMPLETED BY STUDENT

Student Name Sex: M F Birth Date:

Program:

Have you had a serious illness, injury or surgery? Yes No If yes, please describe:

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

1. Current complaints or disabilities, including pregnancy, pertinent to the student's participation in training program:

2. Medications used, prescription, and over-the-counter (use back if necessary):

Name	Indication	Frequency

3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases, pregnancy:

4. Examination comments and findings:

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STUDENT SIGNATURE IS REQUIRED

I give permission to release a copy, pages 2 & 3 of this form to the affiliating facility, If necessary.

Signature ____ Date ________________

Print Name ____

TO COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

Immunization	Documented Dates (attach documentation)		Initials	Comments
Required Tuberculosis Screening: (2-step TST) 1-Step One – (If positive, a CXR must be done)	Date	Result in millimeters		
2-Step Two - (If 1st is negative, redone in 1 -3 weeks)	Date	Result in millimeters		
Blood Test (QFT-G, QFT-GIT, OR T-Spot) List test done:	Date	Result		
Chest X-Ray (if needed to confirm Positive TST)	Date	Result		
Hepatitis B Vaccine 1	Date	Result		
Hepatitis B Vaccine 2 – (4 weeks after 1st)	Date	Result		
Hepatitis B Vaccine 3 – (5 months after 2nd	Date	Result		
Flu Vaccine (Seasonal)	Date	Result		

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MEDICAL FINDINGS:

Height: ft. in. Weight: lb. Vital Signs: TPR BP

Vision:

Without GL (R) 20/ (L) 20/

With GL (R) 20/ (L) 20/

Hearing:	Heart:
Eyes:	Lungs:
Ears:	Abdomen:
Nose:	Bones/Joints:
Throat:	Varicose Veins:
Teeth/Gums:	Feet:
Lymph Nodes:	Posture:
Thyroid:	Skin
Breasts	Other:

GENERAL CONDITION: Any restrictions on lifting/moving and why?

I consider the applicant to be:

( ) Well suited for admission to the program

( ) Not suited for admission to the program

I certify that the student does not have any health condition that would create a hazard to him/herself, fellow students, employees or patients.

Physician

Address

Date