Altra Academy
HOME HEALTH AIDE TRAINING

Home Health Aide Student Physical Form

Name: _____ (Sex) M ____ F ____ Birthdate: _____

Address _____ City _____ State _____ Zip _____ Phone _____

Have you had a serious illness, injury or surgery? _____ If yes, describe:

_____

TO BE COMPLETED BY EXAMINING PHYSICIAN / NURSE PRACTITIONER

1. Current complaints/disabilities pertinent to student's education in a Home Health Aide Program:
   _____
2. Medications used: Prescription and over-the-counter (*use back if additional space needed*)
   NAME INDICATION FREQUENCY
   _____
   _____
   _____
3. Significant medical history: accidents, deformities, surgeries, back problems, communicable diseases, etc.
   _____
   _____
4. Is student able to lift at least 50 pounds, multiple times per shift?:
   _____
5. Examination comments and findings:
   _____
   _____

REQUIRED Tuberculosis Screening ***Attach P.P.D. and Chest X-Ray result forms***

P.P.D. (within 1 year) Date: _____ Results: _____ Chest X-Ray (if PPD is positive) Date: _____ Results: _____

6. RECOMMENDED IMMUNIZATIONS: Please give dates and provide copy of immunization records or serological confirmation.

Diptheria & Tetanus	1st _____	2nd _____	3rd _____	Booster required every 10 years
Polio (complete series)	1st _____	2nd _____	3rd _____	Booster (year)
Rubeola	1st _____	2nd _____	3rd _____	or documented physician diagnosis of serological immunity
Rubella	1st _____	2nd _____		or documented physician diagnosis of serological immunity
Hepatitis B	1st _____	2nd _____	3rd _____	or documented physician diagnosis of serological immunity

The above named student has no communicable or disabling disease or health condition that would create a hazard to himself, classmates, patients or others at this time. He/She is able to perform the physical activities required for this training class.

Examiner Name & Signature _____ Date: _____

Address: _____

I give permission to release a copy of this form to Altra Academy.

Student Signature: _____ Date: _____