**VIP NURSING SCHOOL, Inc.**
**16388 East 14th Street, San Leandro, California 94578**
**Office: (510) 481-0240; (510) 481-0360: Fax: (510) 481-0242**
**Web Site: www.vipnursing.net; Email: info@vipnursing.net**

# STUDENT PERSONAL HEALTH QUESTIONAIRE

**Name**: _____ _____ _____
Last First Middle Initial

**Address:** _____ _____ _____ _____ _____
Street Address Apt. # City State ZIP Code

**Phone:** ( ) _____ ( ) _____ ( ) _____
Home Phone Work Phone Cell Number

**Sex:** ( ) Male ( ) Female **Date of Birth:** _____ **Place of Birth:** _____

**In case of emergency, who should we contact:** _____ **Tel:** _____

**Have you had or do you have any of the following? (Check YES or NO after each question.)**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Dizziness | | | Hernia (rupture) | | | Cancer or tumors | | |
| Frequent headaches | | | Stomach ulcers | | | Asthma | | |
| Fainting spells | | | Pneumonia | | | Hay fever | | |
| Chest pains | | | Pleurisy | | | Diabetes | | |
| Heart palpitation | | | Bronchitis | | | Nervous breakdown | | |
| Chronic Cough | | | Tuberculosis | | | Rheumatism | | |
| Shortness of breath | | | Kidney Stones | | | Arthritis | | |
| Allergies | | | Nephritis | | | Injuries | | |
| Seizures | | | Malaria | | | Operations | | |
| Hypertension | | | Rheumatic fever | | | Back injury | | |
| Jaundice | | | Paralysis | | | Other serious illness | | |

**Injuries, operations, serious illness, please explain**: _____
_____

**Date of Last Visit to Physician**:_____ **Reason**: _____

**Date of Last Hospitalization**: _____ **Reason**: _____

**Have you received any disability payments or compensation for the injury? If so, please explain**:
_____

_____

**Do you have any physical problem which may interfere with your Clinical Training with the School? If so, please explain:** _____

_____

**I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND GIVE THE EXAMINING PHYSICIAN PERMISSION TO SUBMIT A COPY OF THIS REPORT TO VIP Nursing School, Inc.**

_____ _____
**Student's Signature** **Date**

**Records must be kept for five (5) years. VIP School**

**VIP Nursing School, Inc.**
16388 East 14th Street, San Leandro, California 94578
Office: 510.481.0240: 510.481-0360: Fax: 510 481-0242
Web Site: www.vipnursing.net; Email: info@vipnursing.net

## O. PHYSICAL MEDICAL EXAMINATION FORM:

**Name:** _____ **Sex:** Male{ } Female{ }
Last Name First Name Middle Initial

**Address:** _____ _____ _____ _____ _____
Street Name Apt.# City State ZIP Code

**Home Phone**:(____)_____ **Work Phone**:(____)_____ **Cell**:(____)_____

**To Be Completed by Examining Physician or by a Nurse Practitioner: Please submit on the first (1st) week of the class prior to clinical training.**

**Current complaints or disabilities to the student's education in the Nursing Assistant/Home Health Aide applicant:**

_____

_____

**Medications used: Prescription and Over-the-Counter:**

| Name of the Drug | Reason | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Significant medical history, accidents, deformities, surgeries, back problems, hepatitis, etc.:**

_____

_____

**Examination, comments and findings of examination:** _____

## REQUIRED SCREENING:

**PPD: Should be done within 6 months of patient care by the student is required for the Nursing Assistant (NA) /Home Health Aide (HHA) applicant.**

**Date of PPD:** _____ **Results:** _____ **Chest X-ray ( If PPD is Positive). Date:** _____ **Result:**_____**for T.B.**

**Date of Hepatitis Screen:** _____**Results:** _____ **(Not Applicable for NA/HHA applicant)**

The above named patient has no communicable or disabling disease nor any health condition that would create a hazard to himself / herself, fellow employees or to patients at this time. He / She is able to perform the physical activities required for the nursing program for which the individual is applying.

_____ _____ _____
Print Examiner's Name Examiner's Signature Date

_____ _____ _____ _____ _____
Address Street City State Zip Code Phone Number

**I give permission to release a copy of this physical examination form to the contracted clinical facility.**

_____ _____
Student's Signature Date

Records must be kept for 5 (five) years. VIP School