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

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O. PHYSICAL MEDICAL EXAMINATION FORM:

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

Address: ______________________ ______ ________ ________ ________
Street Number 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 Number Street Name **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**

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