



Bay Area CNA School

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Dublin, CA 94568

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Student Information

Full Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Email Address: _____

Physical Examination (To be completed and signed by a Healthcare Provider - an MD, DO, Nurse Practitioner (NP), Physician Assistant (PA), or a School/College Health Center Provider who holds one of these licenses.)

Reason for PE: Nursing school and skilled nursing facility requirement

Medical History

Current Medications: _____
Allergies (including medications, food, etc.): _____
Past Surgeries/Hospitalizations: _____
Chronic Illnesses/Conditions: _____
Family Medical History (relevant conditions): _____

Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Examination Findings

Are there any abnormalities of the following systems (Circle YES or NO)

1. Skin	YES	NO	10. Metabolic (Endocrine)	YES	NO
2. Lymph nodes	YES	NO	11. Neuropsych	YES	NO
3. ENT	YES	NO	12. Now under treatment:		
4. Eyes	YES	NO	Medical	YES	NO
5. Neck	YES	NO	Emotional	YES	NO
6. Lungs	YES	NO	13. Conversational hearing	YES	NO
7. Heart	YES	NO	14. Past major illness/injury	YES	NO
8. Abdomen	YES	NO	15. History of allergy	YES	NO
9. Genito-urinary	YES	NO	16. Color blindness	YES	NO

Healthcare Provider Certification

I certify that I have examined the above-named student and find them to be in good physical and mental health, and fit to undertake a nursing assistant program.

Healthcare Provider's Name: _____ Date: _____

Healthcare Provider's Signature (MD, DO, NP, PA) _____

Clinic/Hospital Name _____ Phone Number: _____

Address: _____ City _____ State _____ Zip _____