CALIFORNIA ALLIED HEALTH INSTITUTE

Certified Nursing Assistant (CNA) Program

Student Health Screening & Immunization Verification/Clearance Form

STUDENT INFORMATION

Student Name: _____Date of Birth: ____ / ____ / _____

Address: _____**City/State/ZIP:**_____

Phone Number: _____**Email Address:** _____

HEALTH HISTORY QUESTIONNAIRE

Please check all that apply.

Medical Conditions

☐ Asthma ☐ Diabetes

☐ Hypertension ☐ Seizure Disorder

☐ Heart Disease ☐ Respiratory Condition

☐ Mental Health Condition ☐ Physical Disability

☐ None

☐ Other: _____

Communicable Diseases History

Have you ever been diagnosed with:

Condition	Yes	No
Tuberculosis (TB)	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
HIV/AIDS	☐	☐
COVID-19 Complications	☐	☐

If yes, explain: _____

Current Medications

Allergies

☐ No Known Allergies

☐ Medication Allergies: _____☐ Food Allergies: _____

☐ Other Allergies: _____

PHYSICAL EXAMINATION (To be completed by a Health Care Provider)

Date of Examination: ____ / ____ / _____

Vital Signs

Height: _____Weight: _____Blood Pressure: _____Pulse: _____Respirations: _____

Physical Assessment

Assessment Area	Normal	Abnormal
General Appearance	☐	☐
Vision	☐	☐
Hearing	☐	☐
Cardiovascular	☐	☐
Respiratory	☐	☐
Musculoskeletal	☐	☐
Neurological	☐	☐
Skin	☐	☐

Comments:

IMMUNIZATION REQUIREMENTS

Measles, Mumps, Rubella (MMR)

☐ Documentation of 2 doses attached

OR

☐ Positive Titer Attached

Date Dose 1: ____ / ____ / _____ Date Dose 2: ____ / ____ / _____

Varicella (Chickenpox)

☐ Documentation of 2 doses attached

OR

☐ Positive Titer Attached

Date Dose 1: ____ / ____ / _____ Date Dose 2: ____ / ____ / _____

Hepatitis B

☐ 3-Dose Series Completed

OR

☐ Positive Titer Attached Titer Date: ____ / ____ / _____

OR

☐ Declination Form Attached

Dose 1: ____ / ____ / _____ Dose 2: ____ / ____ / _____ Dose 3: ____ / ____ / _____

Tdap (Tetanus, Diphtheria, Pertussis) (Must be within the last 10 years)

Date Administered: ____ / ____ / _____

Influenza Vaccine

Current Season Vaccine Received:

☐ Yes Date: ____ / ____ / _____

☐ No (Declined)

COVID-19 Vaccine (if required by clinical partner)

☐ Vaccination Record Attached Date: ____ / ____ / _____

☐ No (Declined)

TUBERCULOSIS (TB) SCREENING

TB Testing

Option 1: TB Skin Test (PPD)

Date Placed: ____ / ____ / _____ Date Read: ____ / ____ / _____

Result: _____ mm

☐ Negative ☐ Positive

Option 2: IGRA Blood Test

Date: ____ / ____ / _____

☐ Negative ☐ Positive

If Positive Test:

Chest X-Ray Date: ____ / ____ / _____

Result:

☐ Negative for Active Disease ☐ Further Evaluation Required

FUNCTIONAL ABILITIES ASSESSMENT

The student is able to:

Ability	Yes	No
Lift/push/pull up to 50 lbs	☐	☐
Stand for prolonged periods	☐	☐
Bend, stoop, and reach	☐	☐
Perform patient transfers	☐	☐

Ability	Yes	No
Communicate effectively	☐	☐
Respond to emergencies	☐	☐

Comments:

HEALTHCARE PROVIDER CERTIFICATION

I certify that I have examined the above-named student and found them:

☐ Medically cleared without restrictions for participation in CNA training and clinical activities.

☐ Medically cleared with the following restrictions:

☐ Not medically cleared pending further evaluation.

Provider Name/Title: _____License #: _____

Clinic Name: _____ Phone: _____

Provider Signature: _____ Date: ____ / ____ / _____

STUDENT ATTESTATION

I certify that the information provided is accurate to the best of my knowledge. I understand that falsification or omission of health information may result in removal from clinical training.

Student Signature: _____

Date: ____ / ____ / _____

Required Attachments:

- Physical Examination Report
- Immunization Records
- TB Screening Documentation

For School Use Only

☐ Health Clearance Complete

☐ Immunization Requirements Met

☐ TB Clearance Verified

☐ Approved for Clinical Placement

Reviewed By: _____ Date: _____