

**THE INTENTIONAL GROUP CNA TRAINING PROGRAM**

**PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM**

**DATE OF EXAM** \_\_\_\_\_

**School** \_\_\_\_\_

**Name** \_\_\_\_\_

**Sex** \_\_\_\_\_ **Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Phone** \_\_\_\_\_ **Work** \_\_\_\_\_

**Personal physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**In case of emergency, contact: Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_ **Phone (H)** \_\_\_\_\_ **(W)** \_\_\_\_\_

**BP:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_ **R:** \_\_\_\_\_ **Temp:** \_\_\_\_\_ **Sat:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**Answer yes or no to the questions below. Explain "Yes" answers below.**

1. Have you had a medical illness or injury since your last check up or physical?
2. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
3. Do you have an ongoing or chronic illness?
4. Do you cough, wheeze, or have trouble breathing during or after activity?
5. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?
6. Do you have seasonal allergies that require medical treatment?
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
8. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
9. Do you wear glasses, contacts, or protective eyewear?
10. Do you have any problems bending, squatting, walking or standing for more than 12 hours?
11. Have you ever had chest pain during or after activities?

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12. Do you have any problems lifting, pulling, pushing?
13. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below.
- Head\_\_\_ Elbow\_\_\_ Hip\_\_\_ Neck\_\_\_ Forearm\_\_\_ Thigh\_\_\_ Back\_\_\_ Wrist\_\_\_ Knee\_\_\_
  - Chest\_\_\_ Hand\_\_\_ Shin/calf\_\_\_ Shoulder\_\_\_ Finger\_\_\_ Ankle\_\_\_ Eyes\_\_\_ Feet\_\_\_
14. Have you had a severe viral infection in the last month?
15. Has a physician ever denied or restricted your participation in any activities for any heart problems?
16. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
17. Do you have frequent or severe headaches?

The above information is correct to the best of my knowledge. Placement in a clinical/ lab within a health career program is conditional in that you must be physically capable and emotionally stable to perform the essential functions required in the specific program with or without reasonable accommodations and be free from communicable diseases in the opinion of your health care provider. A medical examination by a legally qualified healthcare provider is required. The examination must be complete and on file in the health Careers Division prior to the first day of Clinicals. **You must submit documentation of immunizations with this form. Physicals cannot be older than four months from your first day of class.** I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to The Intentional Group CNA Program in connection with any investigation or inquiry concerning the student's eligibility to participate and/or any possible violation of The Intentional Group CNA Program rules. The Intentional Group CAN Program will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

**Signature of Student** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Provider** \_\_\_\_\_ **Date** \_\_\_\_\_