STARR STNA LLC

Nurse Aide Training Program

HEALTH HISTORY
To be completed by the student:

PLEASE PRINT ALL INFORMATION

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Date of Birth: _____ Phone: _____
Month / Day / Year Primary

Classes to Begin on: _____ E-mail: _____
Month / Day / Year Primary

Please answer all questions. If the answer is "No, None, Not Applicable", write that as your answer.

List all allergies and ensitivities you have including medications, food, and environmental:

_____

_____

_____

List all surgical operations you have had with the dates:

_____

_____

_____

List any previous significant health problems you have had:

_____

_____

_____

Student Signature: _____ Date: _____