School Health Physical Form

Top Knowledge Healthcare Institute
19 East Fayette Street, Suite 401
Baltimore, MD 21202
Phone:410-528-1600|Fax:410-528-1663

Section A (REQUIRED): Print legibly in blue or black ink

First Name | Middle Name | Last Name | Social Security Number

Date of Birth | Place of Birth | Age | Sex

Local Address

Phone Number | Email Address

Emergency Contact | Relationship | Home Number | Cell Number | Work Number

Section B (REQUIRED): Print legibly in blue or black ink

Physical Examination		
Height: Weight:	Pulse: Respirations:	Blood Pressure:
	Normal	**Abnormal Findings: (Please explain)**
General Appearance		
Head/Face/Scalp		
Mouth/Throat		
Eyes/Ears/Nose		
Lungs/Chest		
Heart		
Pulses		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurological		
Skin/Hair		

Physical Requirements: All students will be required to meet the same physical demands as are required by employees of the clinical site facility. This may include, occasional and even prolonged physical activity, such as walking, standing, sitting, and lifting as much as 50 pounds or more.

☐ Cleared to begin the Certified Nursing Assistant program without any restrictions

☐ Not Cleared to begin the Certified Nursing Assistant program without any restrictions

I have examined the above-named student and have completed the health form. The student does not present with any contraindications that will limit their ability to participate in the Certified Nursing Assistant program.

Name of Provider (title): _____ Phone Number:_____

Address: _____

Signature of provider: _____ Date: _____

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Section C (REQUIRED): Print legibly in blue or black ink

Tuberculosis Skin Test-(TST) Must have been performed in the last 12 months		
Placement Date: _____ MM/DD/YYYY	Read Date: _____ MM/DD/YYYY	Result: Attach copy of Lab Report

OR

TB Blood Tests- Must have been performed in the last 12 months.		
QuantiFERON-TB Gold or T-Spot **(Circle one)**	Date: _____ MM/DD/YYYY	Result: Attach copy of Lab Report

Chest X-ray-Required only if TST or TB Blood Tests were positive.		
Date: _____ MM/DD/YYYY	Normal or Abnormal **(Circle one)**	Result: Attach copy of Radiology Report

Section D (RECOMMENDED): Print legibly in blue or black ink. Students electing not to receive the Hepatitis B Vaccination are required to sign the Hepatitis B waiver form.

Hepatitis B Vaccination		
Dose 1: _____ MM/DD/YYYY	Dose 2: _____ MM/DD/YYYY	Dose 3: _____ MM/DD/YYYY

I have completely reviewed the information presented on this form and certify that it is <u>complete and accurate.</u>

Name of Provider (title): _____ **Phone Number:**_____

Address: _____

Signature of provider: _____ **Date:** _____