School Health Physical Form

Top Knowledge Healthcare Institute
22 Light Street, Suite 405
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 ______

Date 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 9 months		
Placement Date: __________________ MM/DD/YYYY	Read Date: __________________ MM/DD/YYYY	**Results**

OR
OR

TB Blood Tests- Must have been performed in the last 9 months.		
QuantiFERON-TB Gold or T-Spot (Circle one)	Date: __________________ MM/DD/YYYY	**Results**

Chest X-ray-Required only if TST or TB Blood Tests were positive.		
Date: __________________ MM/DD/YYYY	Normal or Abnormal (Circle one)	Results: 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 complete and accurate.

Name of Provider (title): ________________________________ **Phone Number:**_________________

Address: ____

Signature of provider: ____ **Date:** __________________