

School Health Physical Form

Top Knowledge Healthcare Institute
 11 East Mount Royal Avenue, Suite 001
 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 6 months		
Placement Date: <hr style="width: 80%; margin: 0;"/>	Read Date: <hr style="width: 80%; margin: 0;"/>	<u>Results</u>
MM/DD/YYYY	MM/DD/YYYY	

OR

Tuberculosis Blood Test: Must have been performed in the last 6 months		
Quantiferon-TB Gold or T-Spot (Circle one)	Date: <hr style="width: 80%; margin: 0;"/>	<u>Results</u>
	MM/DD/YYYY	

Chest X-ray-Required only if TST or TB Blood Tests were positive.		
Date: <hr style="width: 80%; margin: 0;"/>	Normal or Abnormal (Circle one)	Results: Attach copy of Radiology Report
MM/DD/YYYY		

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: <hr style="width: 80%; margin: 0;"/>	Dose 2: <hr style="width: 80%; margin: 0;"/>	Dose 3: <hr style="width: 80%; margin: 0;"/>
MM/DD/YYYY	MM/DD/YYYY	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:** _____