

**Med-Cert Training Center**  
**20 West Grace Street, Suite D, Bedford, OH 44146**  
**Phone (440) 786-2378 / Fax (440) 786-7327**

**STUDENT HEALTH FORM**

Name	Class enrolling in:
Address	Month _____ Day _____ Year _____
Phone Number	Circle one: Mon/Wed    2-Week    Evening    Weekend

**Requirements for Clinical Participation**

(Both the section for TB Test and Verification of health must be completed)

## 2-Step TB Test

2-Step TB testing is required to participate in clinical practice. Please record the results below.

<b><i>Test #</i></b>	<b><i>Date Given</i></b>	<b><i>Forearm site</i></b>	<b><i>Given By</i></b>	<b><i>Date Read</i></b>	<b><i>Results</i></b>	<b><i>Read By</i></b>
<b>#1</b>		<b><i>R or L</i></b>			_____mm	
<b>#2</b>		<b><i>R or L</i></b>			_____mm	

If a positive skin test reaction is noted and a chest x-ray is required a copy of the x-ray results must accompany this form.

Comments:

\_\_\_\_\_  
*Signature/Title/Agency (where TB Test was done)*

\_\_\_\_\_  
*Date*

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

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

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

## Physical Exam

Each student participating in the nursing assistant/home health aide training program is required to successfully pass a complete physical examination and be certified as physically fit to participate.

*After review of the above named individual's medical history I certify that he/she is able to fully participate in the nursing assistant/home health aide training program without restriction. Please comment below if restrictions are recommended.*

**Check One:**    ☐ **Full Participation**

☐ **Cannot Participate**

Comments:

\_\_\_\_\_  
*Signature/Title/Agency*

\_\_\_\_\_  
*Date*

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

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

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