

Student Name _____ Date of Birth _____



ELLE SAIT LEARNING LLC dba E. S. Learning

106 Straube Center Blvd; Suite F – 108

Pennington NJ 08534

Telephone: 1800-784-5182 Email: gathey@eslearn.org

STUDENT PHYSICAL EXAMINATION FORM

I. STUDENT INFORMATION

Name: _____

Date of Birth: _____

SS#: _____

Address: _____

City/State: _____

ZIP Code: _____

Program / Role (Check one):

- Home Health Aide
- Certified Nurse Assistant

Physical Type (Check one):

- Annual
- Return to School
- Pre-School Entrance

Consent for Examination and Release of Information:

Signature of Student: _____ Date: _____

II. CLINICAL REQUIREMENTS

The individual must receive the following:

- Physical
- Quantiferon or PPD (2 Step) or Negative Chest Xray
- Flu Vaccination
- Covid Vaccination (Optional in Some clinical sites)

ALL AREAS MUST BE FULLY COMPLETED BEFORE THE START OF CLASS

Student Name _____ Date of Birth _____



III. PHYSICIAN EVALUATION (FOR PHYSICIAN ONLY)

Note to Physician: The above named is/will be employed as a health care provider. Please evaluate the person's ability to function based on physical examination.

Medical History

Neurological (Seizures, Dizziness, Fainting, Weakness/Paralysis): YES NO

Infectious Disease (TB, Hepatitis, Mumps, Measles, Syphilis, Gonorrhea): YES NO

Drug/Alcohol Use (Depressants, Stimulants, Narcotics, Alcohol): YES NO

Physical Examination

Weight: _____ Height: _____

BP: _____ RESP: _____ TEMP: _____ PULSE: _____ PAIN _____ POX _____

Condition Check (Normal/Abnormal):

Eyes: Normal Abnormal

Ears: Normal Abnormal

Nose: Normal Abnormal

Throat: Normal Abnormal

Heart: Normal Abnormal

Lungs: Normal Abnormal

Back: Normal Abnormal

IV. TUBERCULOSIS & IMMUNIZATION

STEP ONE PPD: Admin Date: _____ Time: _____ Read Date: _____ Results: _____ mm

STEP TWO PPD: Admin Date: _____ Time: _____ Read Date: _____ Results: _____ mm

Chest X-Ray / QuantiFERON Results: _____

Influenza Vaccine: Manufacturer: _____ Lot: _____ Exp: _____ Date: _____

Student Name _____ Date of Birth _____



V. PHYSICIAN CERTIFICATION

I certify that I have conducted a physical examination on the above-named person on this date and he/she is free of any communicable disease and from habituation and addition to alcohol, narcotics, stimulants, drugs or other substances, which may alter behavior. In my opinion, he/she can adequately perform the functions of a health care provider.

Physician's Name: _____ NPI#: _____

Physician's Signature: _____ Date: _____

Address: _____ Telephone: _____

Reviewed By: _____ Date: _____

WARNING: All forms must only be completed by Health Care Personnel. Any misleading information will be grounds for dismissal.