



MEDICAL CERTIFICATE OF FITNESS
for
EDUCATION ASSISTANT PROGRAM

INSTRUCTIONS FOR COMPLETING THE MEDICAL CERTIFICATE OF FITNESS PROVIDED ON THE REVERSE SIDE OF THIS FORM

Dear Physician:

The individual identified below has registered to attend the health related course indicated at KLC College: Healthcare, Business, Education. Because of physical demands of this training and profession, it is necessary to determine the appropriateness of the individual to the course.

Does this individual have any limitations which could interfere with any of the above indicated physical demands required?
YES [] NO []

Please explain (if Yes) _____

The following verification must be completed, with results recorded, if checked off: (placement location policy dictates these requirements)

1.) TWO-STEP Mantoux Test

Date of T.B. Step One _____ Result _____

Date of T.B. Step Two _____ Result _____

2.) VERIFICATION FOR IMMUNITY TO CHICKEN POX, MEASLES, RUBELLA, AND MUMPS

Date _____ Positive [] Negative []

Please note: If testing is done through the Health Unit, results must be forwarded to your family physician for completion of this form..

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (PRINTED): _____

TELEPHONE: _____

DATE FORM COMPLETED: _____

STUDENT'S NAME: _____

ADDRESS: _____

POSTAL CODE: _____ TELEPHONE: _____

DATE OF BIRTH: _____
Day Month Year

KLC COLLEGE: HEALTHCARE, BUSINESS, EDUCATION DOES NOT ASSUME RESPONSIBILITY FOR ANY CHARGES OR FEES INCURRED FOR COMPLETION OF THIS FORM OR ANY RELATED TESTING.

KLC College: Healthcare, Business, Education
742 Arlington Park Place, Kingston, ON K7M 8H9
Phone: (613) 384-6194 * Fax: 613-384-9459 * Toll: 1-888-732-0326 * Email: klc@cogeco.net

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