



**Professional School of Massage**  
**131 East Maple Avenue, Langhorne, PA 19047 (215) 750-0700**



**STUDENT HEALTH CERTIFICATION FORM**

This section to be completed by student:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Do you have any chronic or ongoing conditions? (If yes, please explain) \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing a doctor for any reason? (If yes, please explain) \_\_\_\_\_

\_\_\_\_\_

Are you taking any medication on a regular basis? (If yes, please explain) \_\_\_\_\_

\_\_\_\_\_

Do you have or are prone to any skin rashes or other skin problems? (If yes, please explain) \_\_\_\_\_

\_\_\_\_\_

**This section to be completed by student's physician:**

I, \_\_\_\_\_, certify that I have examined \_\_\_\_\_

Doctors Name \_\_\_\_\_ on \_\_\_\_\_ and have found him/her

Date \_\_\_\_\_ to be in good health and free of contagious disease.

Additionally, it is my opinion that he/she is physically, mentally and emotionally able to perform and receive movements and manipulations required of a massage therapy student.

I further certify that a TB Tine test was administered on \_\_\_\_\_ with \_\_\_\_\_ results.

Date \_\_\_\_\_ Positive/Negative

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Certification Date

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Office Address