



Southern Union

State Community College
Health Sciences Division

Health Questionnaire

Directions: Complete Health Questionnaire and Essential Functions Verification Form for specific program. Obtain physical examination and signatures from Physician and/or Nurse Practitioner (See Required Form). Sign all forms in the spaces indicated. Return the completed forms to Mrs. Leak in the Health Sciences Department.

Student Name (Last, First, M)	Telephone () -	SUSCC Student Number
Date of birth:		
Program (Circle one):		
Registered Nursing	EMT-Basic	Radiologic Technology
Practical Nursing	EMT-Paramedic	Surgical Technology
Allergies (Food/Drug/Latex, etc)		

ATTACH MEDICAL DOCUMENTATION OF ALL OF THE FOLLOWING. (State immunization records, Health Dept records, or records from a private physician's office are appropriate documentation. Documentation cannot be from a parent's statement. Documentation must be submitted prior to registering for any health science course. No exceptions can or will be made regarding submission of documentation by a medical professional.)

1. Varicella (Chicken Pox) - attach documentation of vaccine, titer or illness. A titer is required if you are unable to provide medical documentation of the vaccine or illness.

2. MMR (Rubella, Rubeola, Mumps) – attach documentation of two (2) vaccines, titer, or illness. If you are unable to provide documentation, a titer is required. If your titer is negative, you must repeat immunizations.

3. Tetanus (Td) - attach documentation of injection within 10 years.

4. PPD or Tuberculosis (TB) - attach documentation of a current TB skin test with results OR documentation of a chest x-ray. A TB skin test is current for one year from administration date. A chest x-ray is required if you have ever had a positive skin test. (X-rays are current for 2 years) Your TB skin test must be current during the entire semester.

5. Hepatitis B series – attach documentation of injections or titer results. You must have documentation of the first of a series of 3 immunizations before registering for the first level course. Proof of 2nd & 3rd vaccines must be submitted when due. A waiver is available for those unable to receive the vaccine (see Health Sciences Department for waiver.)

COMPLETE	Height _____ Weight _____ BP _____ / _____ Pulse _____		
	Vision Right 20/ _____ Left 20/ _____ Corrected: Y N		
	LIMITED	NORMAL	ABNORMAL FINDINGS
		Cardiovascular	
		Pulses	
		Heart	
		Lungs	
		Skin	
		E.N.T.	
		Gastrointestinal	
		Musculoskeletal	
		Neurological	
	Other		

Has student been diagnosed with any chronic/serious medical condition(s)? (ex. diabetes, hypertension, seizure disorders, etc.?) **Yes** **No** **If yes, please list:**

Has student been diagnosed with any psychiatric/mental condition(s)? (ex. bipolar, depression, chemical dependency, etc.) **Yes** **No** **If yes, please list:**

Are the above conditions being presently controlled or treated? **Yes** **No** **If so, please describe:**

Is student taking any prescribed medications on a regular basis? If so, please list: -

On the basis of the examination on this day, I approve this student's participation in Health Sciences Clinical. **Yes** **No** **Limited** **If limited, comment is required.**

Physician's PRINTED Name, Address, and Phone Number	
_____ Physician's Signature	_____ Date

For the purpose of determining eligibility for my educational experiences, I hereby give my permission for the Division of Health Sciences to contact the Physician who completed this health form for further information if needed. I understand that this form may be duplicated for a clinical agency upon request. NOTE: Additional medical examinations and a specific release from a physician may be required any time (for example, during pregnancy, infectious disease, interference with mobility, emotional instability, etc.) if it is deemed necessary for the faculty to evaluate your state of health.

Student's Signature

Date

Please complete & attach Technical / Essential Standards for specific area of training.