



Southern Union

State Community College
Health Sciences Division

Annual Health Questionnaire (for currently enrolled students)

| | | |
|--------------------------------------|-------------------------------|-----------------------------|
| Student Name (Last, First, M) | Telephone () - | SUSCC Student Number |
|--------------------------------------|-------------------------------|-----------------------------|

| | | | |
|-----------------------------|---------------------------|----------------------|------------------------------|
| Program (Circle one) | Registered Nursing | EMT-Basic | Radiologic Technology |
| | Practical Nursing | EMT-Paramedic | Surgical Technology |

Allergies (Food/Drug/Latex, etc)

| | | | |
|-----------------|--|------------------|--------------------------|
| 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 yes, 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 _____