Student Health Questionnaire

Name	(Last)	(First)			(Middle)	
Address		(City)			(State)	(Zip)
Phone		**Gender:**	☐ Male	☐ Female	**Age**	
Emergency Contact	(Name)				(Phone)	
Family Physician	(Name)				(Phone)	

Have you had or do you have any of the following conditions:

	Yes | No		Yes | No		Yes | No
Dizziness	☐ ☐	Hernia	☐ ☐	Cancer or Tumors	☐ ☐
Frequent Headaches	☐ ☐	Stomach Ulcers	☐ ☐	Asthma	☐ ☐
Fainting Spells	☐ ☐	Pneumonia	☐ ☐	Hay Fever	☐ ☐
Chest Pains	☐ ☐	Pleurisy	☐ ☐	Diabetes	☐ ☐
Short of Breath	☐ ☐	Kidney Stones	☐ ☐	Arthritis	☐ ☐
Chronic Cough	☐ ☐	Tuberculosis	☐ ☐	Rheumatism	☐ ☐
Heart Palpitations	☐ ☐	Bronchitis	☐ ☐	Nervous Breakdown	☐ ☐
Allergies	☐ ☐	Nephritis	☐ ☐	Injuries	☐ ☐
Seizures	☐ ☐	Malaria	☐ ☐	Operations	☐ ☐
Hypertension	☐ ☐	Rheumatic Fever	☐ ☐	Other Serious Illness	☐ ☐

Injuries, Operations, Serious Illenss - Explain:			
Date of last Physician Visit:		**Reason:**	
Have you ever received any disability payments or compensation for an injury or illness? If so, explain:			
Do you have any physical problem which may interfere with your clinical assignments? If so, explain:			
I, the undersigned, certify that the above answeres are true and give the examining physician permission to submit a report to:	**Charles A. Jones Career & Education Center VN & NA also their Clinical Affiliates**		

Student Signature:		**Date:**	

Physical Examination Results On Other Side

Make sure facility stamps your form

TO BE COMPLETED BY THE EXAMINING PHYSICIAN/NURSE PRACTITIONER

List any disabilities pertinent to the students education in the medical/nursing field related to (diagnosis):

Does student have any disability/disabilities that require special accommodations: Yes / No

If yes, what special accommodations will student require:

If yes, will student be able to perform duties within the scope of practice required in the medical/nursing field:

Medications used: (Prescription and Over-the-Counter)

Name	Reason	Frequency

Significant medical history, accidents, illness, deformities, surgeries, back problems, hepatitis, etc.:

Examination comments and findings:

Eyes		GI	
Nose / Throat		GU	
Mouth		Musc / Skeletal	
Neck		Genitals	
Chest / Lungs		Neuro	
Chest / Cardiac			

Infection Free ☐ Fit for Duty ☐ No Restrictions ☐

Requiried Screening

PPD (within 6 mos.)	Date given:		Location:		Date Read:	Result:	
Chest X-ray (if PPD is positive):			Date:		Result:		

Vaccinations

Hep B	Date given:		Hep B	Date given:		Hep B	Date given:		
Hep A	Date given:		Hep A	Date given:					
Tdap	Date given:		MMR	Date given:					
Flu	Date given:		Varicella	Date given:					

The above named student has no communicable or disabling disease or any health condition that would create a hazard to themselves, visitors, fellow emplopyees or to patients at this time. This student is able to perform the physical activities required for the program which the individual is applying to.

(Examiner Name & Signature)		(Date)
(Address)		(Phone)
(City)	(State)	(Zip Code)

I give permission to release a copy of this form to the affiliated clinical facilities:

(Student Signature)

Make sure facility stamps your form