Southern Union

State Community College - Health Sciences

Health Questionnaire

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

Program (Circle one)	Registered Nursing (RN)	EMT	Paramedic	Radiologic Technology
	Practical Nursing (PN)	AEMT	MRI/CT	Surgical Technology

Allergies (Food/Drug/Latex, etc)

Height_____ Weight_____ BP_____/_____ Pulse _____

Vision Right 20/_____ Left 20/_____ Corrected: Y N Color Blind: Y N

			NORMAL	ABNORMAL FINDINGS
COMPLETE	LIMITED	Cardiovascular		
		Pulses		
		Heart		
		Lungs		
		Skin		
		E.N.T.		
		Gastrointestinal		
		Musculoskeletal		
		Neurological		
		Other		

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

_____

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

_____

3. Are the above conditions being presently controlled or treated? **Yes□ No □ If yes, please describe:**

_____

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

_____

5. **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/Nurse Practitioner/Physician's Assistant PRINTED Name, Address, and Phone Number

_____

Name Address Phone #

_____ _____

Physician/Nurse Practitioner/Physician's Assistant'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 Healthcare Provider 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