



Southern Union

State Community College - Health Sciences

Annual Health Questionnaire

Student Name (Last, First, M)		Telephone () -		SUSCC Student Number	
Program (Circle one)	Registered Nursing (RN) Practical Nursing (PN)	EMT AEMT	Paramedic MRI/CT	Radiologic Technology Surgical Technology	
Allergies (Food/Drug/Latex, etc)					
COMPLETE	Height _____ Weight _____ BP _____ / _____ Pulse _____				
	Vision Right 20/ _____ Left 20/ _____ Corrected: Y N Color Blind: Y N				
	LIMITED	NORMAL	ABNORMAL FINDINGS		
	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 #
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Physician/Nurse Practitioner/Physician's Assistant's Signature	Date
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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
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