

PRE-ENROLLMENT HEALTH SCREENING

It is the policy of Hill College Health Science Program to require a health screening prior to enrollment. Medical examination is used to reduce the risk of contamination and the spread of communicable disease.

PRINT APPLICANT NAME: _____ DATE OF BIRTH: _____

I, the above named applicant, will answer all questions accurately, to the best of my knowledge and understand this will be part of my student record.

I consent to the following diagnostic/screening examinations. I understand that follow-up examinations, consultations and treatment by a physician, if required, as a condition of enrollment will be at my own expense.

Applicant's Signature

Date

Note: (The physician must sign the bottom of the front and back)

Applicant: complete the following:

Have you had any of the following? Please circle yes or no and give date of the occurrence on the line provided.

- | | | | |
|------------------------|--------------------|-----------------|--------------------|
| Allergies | yes _____ no _____ | Arthritis: | |
| Operations (Surgeries) | yes _____ no _____ | Gout | yes _____ no _____ |
| Back Injuries | yes _____ no _____ | Rheumatism | yes _____ no _____ |
| Chronic Back Pain | yes _____ no _____ | Fractures | yes _____ no _____ |
| Childhood Diseases: | | Head injury | yes _____ no _____ |
| Measles | yes _____ no _____ | Tuberculosis | yes _____ no _____ |
| Mumps | yes _____ no _____ | Hepatitis | yes _____ no _____ |
| Chicken pox | yes _____ no _____ | Heart Trouble | yes _____ no _____ |
| High Blood pressure | yes _____ no _____ | Fainting spells | yes _____ no _____ |
| Diabetes | yes _____ no _____ | Epilepsy | yes _____ no _____ |
| Sinus Trouble | yes _____ no _____ | Asthma | yes _____ no _____ |
| Varicose Veins | yes _____ no _____ | Skin Disease | yes _____ no _____ |
| | | Hernia | yes _____ no _____ |

Any other condition(s) not covered above? _____

Have you lost more than two weeks from work or school due to injury/illness in the last 5 years?
YES _____ NO _____ if yes, explain: _____

(PRINT) PRIVATE PHYSICIAN NAME: _____

PHYSICIAN SIGNATURE: _____ Date _____

PHYSICAL EXAMINATION: To be filled out by examining physician

Temp. _____ Pulse _____ Resp. _____ BP _____ Height _____ Weight _____
Significant Medical History: _____

Diagnostic Examination Summary: _____

*CBC _____ *UA _____ *RPR _____ *Not a requirement

Physical: place X on line if examined:

eyes _____	lungs _____
ears _____	extremities _____
nose _____	abdomen _____
throat _____	breast _____
teeth _____	heart _____
neck _____	

Findings: _____

Recommendations: _____

NOTE: The student must have proof of: flu vaccine, one (1) Tdap in a lifetime, current Tetanus booster within the last ten (10) years, two (2) MMR's, Hepatitis B Series, and two (2) Varicella immunizations. A serological (titer) confirmation of immunity for MMR's, Hepatitis B, and Varicella will be sufficient for enrollment in the Hill College Health Science program of choice.

Influenza: _____ **TB: Skin Test Date:** _____ **Results:** _____
Chest x-ray Date: _____ **Results:** _____

Tdap - _____ **Tetanus Booster-** _____

MMR #1 – _____ **Measel or MMR #2:** _____
Or Positive Titer Dates: Measles _____ Mumps _____ Rubella _____

Hepatitis B #1 Date: _____ **Hepatitis B #2 Date:** _____ **Hepatitis B #3 – Date:** _____
Or Positive Titer Date: _____

Varicella (Chicken Pox) #1 _____ **#2** _____ or Positive Titer Date: _____

Is applicant physically and emotionally able to perform in assigned position? Yes No

- Emotional and physical health sufficient to meet the demands of the position.
- Strength sufficient to: lift some patients, move heavy equipment on wheels (up to approximately 250 lbs with assistance), and to move patients in wheelchairs and stretchers.
- Ability to maintain prolonged standing, walking, and arm positions necessary for patient care.

If no please explain: _____

Physician's Signature

Date