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 _____
ears _____
nose _____
throat _____
teeth _____
neck _____
lungs _____
extremities _____
abdomen _____
breast _____
heart_____

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**