CARDIOVASCULAR TECHNOLOGY PROGRAM

GROSSMONT COLLEGE
HEALTH PROFESSIONS

Consent Form

Date:____________________________

Name: ____ Birthday: ___________________________
Last First Middle Month Day Year

Address: ____
Street City and State
Zip

Telephone: ____

CONSENT FOR RELEASE OF HEALTH REPORT

I realize that the various health agencies where Health Professions' students gain experience may wish these students to be certified in good health. I hereby consent to the communication of my health record from Grossmont College to those cooperating agencies as they may request.

SIGNATURE ***X***___________________________________ DATE: ____________________
(Applicant)

HEALTH QUESTIONNAIRE (To be completed by applicant. Please respond to each question.)

Do you have any physical limitations which would affect your ability to lift, turn or transfer patients? Yes_______ No _________

Do you have any limitation in use of your senses, such as in sight or hearing, which would limit your ability to practice a health profession? Yes_______ No _________

Do you have any other condition which might interfere with your ability to practice a health profession safely? Yes_______ No _________

If you have answered yes to any of the above, please explain your limitations in detail on a separate sheet of paper.

List any medications you have been taking on a regular or frequent basis during the past year.

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