EKG Technician 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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