

OCCUPATIONAL THERAPY ASSISTANT PROGRAM

GROSSMONT COLLEGE HEALTH PROFESSIONS

Consent Form

Name: _____ Birthday: _____
Last First Middle Month/Day/Year

Address: _____ Telephone _____
Street City, State, Zip

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: _____ 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. Yes _____ No _____

List any medications you have been taking on a regular or frequent basis during the past year. Yes _____ No _____