

Grossmont College  
Nursing Program

Immunization Record and Statement of Health

Date: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First Middle Month/ Day/ Year

Address \_\_\_\_\_  
Street City, State Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

**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:** \_\_\_\_\_

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

1. Do you have any physical limitations which would affect your ability to lift, turn or transfer patients or otherwise restrict you from participating fully in the RN training program?

Yes \_\_\_\_\_ No \_\_\_\_\_ (check one only)

2. 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 \_\_\_\_\_ (check one only)

3. Do you have any other condition which might interfere with your ability to practice a health profession safely?

Yes \_\_\_\_\_ No \_\_\_\_\_ (check one only)

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

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

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