

WCTC HEALTH APPRAISAL FORM

A health service has been provided to offer assistance to any person at WCTC. Nurse practitioners are on duty at the Community Nursing Clinic located in the Service Occupations Building, (262) 695-1888.

To serve your health needs, the Community Nursing Clinic would appreciate any medical information that might help you during school hours should an accident or illness occur. All students, under 18 years of age, must have a signed parent authorization on file in the Community Nursing Clinic.

To all persons completing this form: This form will be kept on file for 7 years.

If any of the following medical conditions pertain to you, please indicate. (Check "yes" or "no." If yes, explain with all necessary information.)

BE SURE TO COMPLETE BOTH SIDES OF THIS FORM.

Yes No

- 1. Allergies (Be Specific): _____
- 2. Arthritis (Type): _____ Medication _____
- 3. Asthma/Breathing Problems, etc. (Type): _____ Medication _____
- 4. Back Problems or Back Surgery: _____ Medication _____
Restrictions/Limitations: _____
- 5. Contact Lenses (Check One): Hard Lens Soft Lens
- 6. Dentures or Partials (Check One): Upper Lower
- 7. Diabetes (How Controlled): Diet Pill _____
Insulin (Type & Amount) _____
- 8. Epilepsy (Type): _____ Medication _____
- 9. Hay Fever: Medication _____
- 10. Hypoglycemia (Low Blood Sugar): Diet Medication _____
- 11. Hypertension (High Blood Pressure): Diet Medication _____
- 12. Heart Conditions (Type): _____ Medication _____
- 13. Hearing Problem: R Ear L Ear Aid Required? Yes No
- 14. Menstrual Problems (Medication): _____
- 15. Migraine Headaches (Medication): _____
- 16. Orthopedic Problems (Bone Condition): _____
- 17. Are you pregnant at this time? Approximate date of delivery: _____
- 18. Do you take any daily medication other than those stated above? _____
- 19. Do you have any physical limitation other than those stated above? _____

20. Any other surgery or existing medical problems you care to list that might help us provide you with better care?

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21. Do you have any visual problems (other than corrective eyewear)? _____
22. Do you have any speech problems? _____
23. Do you need a wheelchair? _____
24. Do you have an artificial limb? _____

Federal law prohibits us from making pre-admissions inquiry about disabilities. Information regarding disabilities, voluntarily given or inadvertently received, will not adversely affect any admission decision.

PLEASE PRINT AND COMPLETE THE FOLLOWING INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Date of Birth: _____ Age: _____

Program you are registered in: _____

Social Security Number: _____ Family Doctor: _____

Phone Number of Family Doctor: () _____

Who to notify in case of emergency: _____ Relationship: _____

Address: _____

Telephone No.: Home () _____ Work () _____

Signature: _____ Date completing form: _____

If student is under 18 years of age, a Parent/Guardian signature is required to be on file.

Parent or Guardian signature: _____

Date signed: _____