



### Job Corps Health Questionnaire (ETA 653)

**PURPOSE:** To determine the health and accommodation/modification needs of the applicant who has been offered enrollment in Job Corps, to obtain and verify consent for required routine medical assessments and/or consent to receive basic health care services, and to determine whether an otherwise-eligible applicant offered enrollment may pose a direct threat to self or others or has health care needs beyond the basic health care services provided by Job Corps.

**INSTRUCTIONS:** Before asking you to answer the questions on this form, Job Corps is required to tell you that:

- Providing the health-related information that this form requests is voluntary – in other words, you may choose not to answer any or all of the health-related questions on this form. Should you choose to answer any or all of the health-related questions, any false statement or dishonest answer may be grounds for separation from Job Corps for the individual named below.
- At the same time, the authorizations that this form requests is a requirement for participation in Job Corps. Therefore, if you do not sign the authorizations, the person whose name appears in Section 1 below will be denied enrollment in Job Corps.
- All disability-related and/or other medical information that you provide in response to the questions on this form, or that Job Corps receives because you sign the authorizations that appear at the end of this form, will be collected and stored separately from any other information about the person whose name appears in Section 1 below.
- The medical and/or disability-related information described above will be kept confidential to the extent permitted by law. This information will only be disclosed in accordance with the requirements of the Department of Labor’s regulations and other applicable federal laws.
- The information will only be used in accordance with Federal law.

Please answer all of the questions to the best of your knowledge. The collection of this information is authorized by Public Law 113-128.

1. Name (Last, First, Middle Initial)

2. Applicant ID

3. Sex (M/F)

4. Height (in)

5. Weight (lb)

6. a. Are you or your family covered by health insurance other than Medicaid?  
(If YES, obtain copy of health insurance card and attach to this form.)

NO  YES

b. Are you or your family covered by Medicaid?  
(If YES, obtain copy of Medicaid card and attach to this form.)

NO  YES

**An answer of “Fair” or “Poor” to question 7, or a YES answer to any item in questions 8, 9, or 10 requires an explanation in question 11 on this form.**

7. What is your general Health Condition (check one):      Excellent     Good     Fair     Poor

8. a. Are you currently under the care of a physician, dentist, or mental health professional?      NO     YES   
How often do you go see the doctor or counselor?      Daily     Weekly     Monthly     Other

b. Are you currently taking any prescription or non-prescription medication, herbs, supplements, vitamins, etc.?

NO     YES

c. Do you use a medical device (e.g., prosthesis, wheelchair, CPAP, hearing aid, etc.)?

NO     YES

d. Do you have any known allergies (e.g., medication, food, etc.)?

NO     YES

e. Do you wear braces on your teeth?

NO     YES

In the **past 2 years** have you

f. Been refused or discharged from military service for medical or mental health reasons?

NO     YES

g.	Had a medical professional (e.g., doctor) advise you to have a medical treatment or surgical procedure that you have not yet received?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
h.	Had a medical treatment or surgical procedure?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
i.	Been hospitalized or treated in an emergency room for medical, mental health, or substance use reasons?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
j.	Had a serious dental problem or problems (e.g., untreated dental infections, missing teeth, unresolved severe toothaches, etc.)?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
k.	Received counseling or treatment for a mental health issue?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
l.	Received counseling or treatment for drug and/or alcohol use?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
m.	Attempted to hurt yourself (e.g., cut yourself, deliberately overdosed on medication or other drugs)?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
n.	Thought about hurting yourself or planned to hurt yourself?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
o.	Intentionally tried to hurt someone else?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
p.	Been afraid that others want to physically harm you?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
q.	Heard voices or seen things that other people did not hear or see?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
r.	Believed that your thoughts were being controlled by someone or something other than yourself?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
s.	Lost control of your anger, or feared losing control of your anger, to the point of hurting yourself or someone else?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
t.	Been in a physical fight that resulted in hospitalization or significant injury of you or the other person?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
u.	Been removed from your home, school or job due to your behavior?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
v.	Stopped getting treatment and/or taking medication that a doctor or other medical professional prescribed for you?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
w.	Participated in a residential or day therapeutic program where you received medical, alcohol or drug abuse, or mental health care?	NO <input type="checkbox"/>	YES <input type="checkbox"/>

9. To your knowledge, have you **EVER had or do you now have** any of the following conditions?

a.	Anemia (including sickle cell disease)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	s.	Learning disabilities (e.g., dyslexia, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
b.	Asthma	NO <input type="checkbox"/>	YES <input type="checkbox"/>	t.	Attention Deficit/Hyperactivity Disorder (ADD or AD/HD)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
c.	Visual impairment/trouble seeing	NO <input type="checkbox"/>	YES <input type="checkbox"/>	u.	Mental Retardation (MR)/ Intellectual Disability/ Developmental Disability	NO <input type="checkbox"/>	YES <input type="checkbox"/>
d.	Hearing impairment/trouble hearing	NO <input type="checkbox"/>	YES <input type="checkbox"/>	v.	Depression	NO <input type="checkbox"/>	YES <input type="checkbox"/>
e.	Obesity	NO <input type="checkbox"/>	YES <input type="checkbox"/>	w.	Anxiety or Trauma and Stress-Related Disorders (e.g., generalized anxiety disorder, panic disorder, post-traumatic stress disorder, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
f.	Diabetes (high blood sugar)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	x.	Obsessive-Compulsive Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
g.	Heart condition	NO <input type="checkbox"/>	YES <input type="checkbox"/>	y.	Disruptive and Impulse Control Disorders (e.g., oppositional defiant disorder, fire-setting, intermittent-explosive disorder, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
h.	High blood pressure	NO <input type="checkbox"/>	YES <input type="checkbox"/>	z.	Schizophrenia	NO <input type="checkbox"/>	YES <input type="checkbox"/>
i.	Kidney, bladder, or urinary problems	NO <input type="checkbox"/>	YES <input type="checkbox"/>	aa.	Conduct Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
j.	Speech problem (e.g., stuttering, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	bb.	Traumatic Brain Injury	NO <input type="checkbox"/>	YES <input type="checkbox"/>
k.	Tuberculosis (TB) or positive TB test	NO <input type="checkbox"/>	YES <input type="checkbox"/>	cc.	Bipolar Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
l.	Ulcer of stomach or intestines or colitis	NO <input type="checkbox"/>	YES <input type="checkbox"/>	dd.	Personality Disorders (e.g., anti-	NO <input type="checkbox"/>	YES <input type="checkbox"/>



conditions such as diabetes, nephritis, and pregnancy, sexually transmitted infections, and to screen for the unlawful use of controlled substances.

- I (we) authorize Job Corps to provide the above-named individual with a DENTAL READINESS INSPECTION and an ELECTIVE ORAL EXAMINATION that includes x-rays and checking the teeth, gums, and tissues of the mouth for disease.
- I (we) authorize Job Corps to provide the above-named individual with basic routine health care and emergency health care, including basic and emergency mental health services, while he/she is enrolled in the Job Corps program. The types of care that are considered "basic routine health care" are listed in the Policy and Requirements Handbook.
- I (we) authorize Job Corps to provide the above-named individual with basic oral health care, which may include procedures such as teeth cleaning, fillings, and extractions that will relieve pain, treat, and help prevent or decrease dental problems.
- I (we) understand the reasons for the medical and oral examinations and laboratory testing and have had the opportunity to ask questions.
- I (we) authorize Job Corps to provide the above-named individual with all age-appropriate immunizations that are currently recommended by the Centers for Disease Control and Prevention.
- I (we) authorize Job Corps to administer a tuberculin skin test or blood test for tuberculosis to the above named individual.
- I (we) certify that the information that has been provided on this medical form is true and complete to the best of my (our) knowledge.
- I (we) understand that any false statement or dishonest answers may be grounds for separation from Job Corps for the above-named individual.
- I (we) understand that refusal to provide the entry Urine Drug Screen (UDS) or to be tested for TB may be grounds for separation from Job Corps for the above-named individual.
- I (we) understand that protected health information will only be released in accordance with the Privacy Act of 1974, any other applicable federal laws (see discussion below), and the current Job Corps Privacy Rule Authorization and Notice.

All disability-related or other medical information that is contained in this health questionnaire, or that is obtained through the authorizations contained in this document, will be collected and maintained separately from other information regarding the applicant offered enrollment, and will be kept strictly confidential. This information will only be disclosed in accordance with the requirements of the Department of Labor's regulations.

The confidentiality requirements expressed in the above paragraph are separate and different from the confidentiality requirements for health information imposed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under the Department of Labor's regulations related to discrimination on the basis of disability, the disclosure of medical and disability-related information about a particular individual is only permitted in accordance with those regulations, even if a recipient, such as a Job Corps contractor or center operator, obtains a signed release form explicitly authorizing disclosure that is or would be inconsistent with those regulations.

Applicant Signature:	Date:
Parent/Guardian Signature (if applicant offered enrollment is a minor):	Date:

Paperwork Reduction Act Public Burden Statement: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number and expiration date. Public reporting burden for this collection of information, which is required to obtain or retain benefits (29 USC 3199), is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. This information collection is for program management. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the US Department of Labor, Office of Job Corps, Room N-4507, Washington, D.C. 20210 (OMB Control No. 1205-0033).