U.S. Department of Labor
Employment and Training Administration

OMB Approval No. 1205-0033
Expiration Date: 3/31/2017

Job Corps Health Questionnaire (ETA 653)

PURPOSE: To determine the health and accommodation/modification needs of the applicant who has been offered enrollment into 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.

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

- Providing the information this form asks for is voluntary – in other words, you may choose not to answer any or all of the questions on this form, or to sign the authorizations at the end of the form that allow Job Corps to receive other medical and/or disability-related information about the individual (person) whose name appears in Section 1 below.
- At the same time, providing the information and authorizations this form asks for is a requirement for participation in Job Corps. Therefore, if you do not provide the information or sign the authorizations, the person whose name appears in Section 1 below may be denied enrollment in Job Corps. However, neither you nor that person will receive any other unfavorable treatment.
- 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 strictly confidential. 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 Pub. L. 105-220, as amended by Pub. L. 105-277.

1. Name (Last, First, Middle Initial)

2. Applicant ID	3. Sex (M/F)	4. Height (in)	5. Weight (lb)

6 What is your general health condition (check one): Excellent ☐ Good ☐ Fair ☐ Poor ☐

7. a. Are you or your family covered by health insurance other than Medicaid? NO ☐ YES ☐
(If YES, obtain copy of health insurance card and attach to this form.)

b. Are you or your family covered by Medicaid? NO ☐ YES ☐
(If YES, obtain copy of Medicaid card and attach to this form.)

An answer of "Fair" or "Poor" to Question 6, or a YES answer to any item in Questions 8, 9, or 10 requires an explanation in Question 11 on the reverse of this form.

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

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 ☐	YES ☐	s.	Learning disabilities (e.g., dyslexia, etc.)	NO ☐	YES ☐
b.	Asthma	NO ☐	YES ☐	t.	Attention Deficit/Hyperactive Disorder (ADD or AD/HD)	NO ☐	YES ☐
c.	Visual impairment/trouble seeing	NO ☐	YES ☐	u.	Mental Retardation (MR) /intellectual disability/ developmental disability	NO ☐	YES ☐
d.	Hearing impairment/trouble hearing	NO ☐	YES ☐	v.	Depression	NO ☐	YES ☐
e.	Obesity	NO ☐	YES ☐	w.	Anxiety disorder	NO ☐	YES ☐
f.	Diabetes (high blood sugar)	NO ☐	YES ☐	x.	Obsessive-compulsive disorder	NO ☐	YES ☐
g.	Heart condition	NO ☐	YES ☐	y.	Impulse-control disorders (e.g., fire-setting, intermittent-explosive disorder, etc.)	NO ☐	YES ☐
h.	High blood pressure	NO ☐	YES ☐	z.	Schizophrenia	NO ☐	YES ☐
i.	Kidney, bladder, or urinary problems	NO ☐	YES ☐	aa.	Conduct disorder	NO ☐	YES ☐
j.	Speech problem (e.g., stuttering, etc.)	NO ☐	YES ☐	bb.	Traumatic brain injury	NO ☐	YES ☐
k.	Tuberculosis (TB) or positive TB skin test	NO ☐	YES ☐	cc.	Bipolar disorder	NO ☐	YES ☐
l.	Ulcer of stomach or intestines or colitis	NO ☐	YES ☐	dd.	Anti-social personality disorder	NO ☐	YES ☐
m.	Epilepsy, seizures, convulsions	NO ☐	YES ☐	ee.	Autism spectrum disorders (i.e., Asperger's or Autism)	NO ☐	YES ☐
n.	Hepatitis	NO ☐	YES ☐	ff.	A mental health problem or concern	NO ☐	YES ☐
o.	Cancer/malignancy	NO ☐	YES ☐	gg.	A drug or alcohol problem or concern	NO ☐	YES ☐

p,	Sleep apnea	NO ☐	YES ☐	hh.	Other health problems or concerns	NO ☐	YES ☐
q.	Organ transplant	NO ☐	YES ☐	ii.	FEMALES: Are you pregnant? If YES, approximate date last menstrual period began. _____	NO ☐	YES ☐
r.	Muscle or bone disorder	NO ☐	YES ☐				
10. If you are a person with a disability, you may request accommodations (changes in the way things are done, or other types of extra support to help you participate in the Job Corps program). Would you like, or do you think you will need, any of these extra supports?						NO ☐	YES ☐

11. Provide explanation below of any YES responses to items in Questions 8, 9, or 10. If additional space is needed, attach separate sheet. If the applicant offered enrollment is not sure whether he/she had one of the conditions mentioned in Question 9, or whether he/she needs an accommodation, include whatever information the applicant offered enrollment provides. If the applicant offered enrollment declines to give additional information, indicate in this section that the applicant offered enrollment declined to respond.

Item	Explanation

- I (we) understand that failure to answer any or all of the questions may result in the above-named individual being denied enrollment in Job Corps.
- I (we) authorize the Job Corps to receive from doctors, dentists, mental-health professionals, clinics, hospitals, or other sources, medical information from the health records of the above-named individual regarding the specific conditions identified in any question in section 8 or 9 of this form to which a "yes" response has been provided. I understand this form does not authorize Job Corps to ask for any records regarding any other health conditions. I also understand that Job Corps is asking for these records to determine (1) the health needs of the above-named individual; (2) whether he/she needs a specific type of extra supports (known as reasonable accommodations) to participate in Job Corps; and (3) whether he/she has a health condition that would pose a direct threat to the individual or others if he/she participates in Job Corps.
- I (we) authorize Job Corps to provide the above-named individual with an ENTRANCE MEDICAL EXAMINATION that includes blood testing to identify conditions such as anemia, syphilis, and HIV infection; and urine testing to identify conditions such as diabetes, nephritis, 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 CURSORY ORAL INSPECTION and a MANDATORY 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 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 care, which may include procedures such as teeth cleaning, fillings, and extractions that will relieve pain and help prevent or decrease dental problems.
- I (we) understand the reasons for the medical and oral examinations and health testing and have had the opportunity to ask questions.

- I (we) authorize Job Corps to provide the above-named individual with all immunizations that Job Corps determines are necessary for that individual.
- I (we) authorize Job Corps to administer a skin 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 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 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 confidentially 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 2881), is estimated to average 5 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).