



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, 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 that 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 that 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. Student 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? 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, 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.	Been hospitalized or treated in an emergency room for medical or mental health reasons?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
i.	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"/>
j.	Received counseling or treatment for a mental health issue?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
k.	Received counseling or treatment for drug or alcohol use?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
l.	Attempted to hurt yourself (e.g., cut yourself, deliberately overdosed on medication or other drugs)?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
m.	Thought about hurting yourself or planned to hurt yourself?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
n.	Intentionally tried to hurt someone else?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
o.	Been afraid that others want to physically harm you?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
p.	Heard voices or seen things that other people did not hear or see?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
q.	Believed that your thoughts were being controlled by someone or something other than yourself?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
r.	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"/>
s.	Been in a physical fight?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
t.	Been expelled from school, fired from a job, or convicted of a crime?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
u.	Been removed from your home by authorities due to your behavior (e.g., charges of disorderly conduct, assault, etc.)?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
v.	Stopped getting treatment and/or taking medication that a doctor or other medical professional wanted you to have?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
w.	Participated in a residential or day therapeutic program where you received medical 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"/>	q.	Mental Retardation (MR) /Intellectual Disability/ Developmental Disability	NO <input type="checkbox"/>	YES <input type="checkbox"/>
b.	Asthma	NO <input type="checkbox"/>	YES <input type="checkbox"/>	r.	Depression	NO <input type="checkbox"/>	YES <input type="checkbox"/>
c.	Visual impairment/trouble seeing	NO <input type="checkbox"/>	YES <input type="checkbox"/>	s.	Anxiety Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
d.	Hearing impairment/trouble hearing	NO <input type="checkbox"/>	YES <input type="checkbox"/>	t.	Obsessive-Compulsive Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
e.	Obesity	NO <input type="checkbox"/>	YES <input type="checkbox"/>	u.	Impulse Control Disorders (e.g., fire-setting, intermittent-explosive disorder, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
f.	Diabetes (high blood sugar)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	v.	Schizophrenia	NO <input type="checkbox"/>	YES <input type="checkbox"/>
g.	Heart condition	NO <input type="checkbox"/>	YES <input type="checkbox"/>	w.	Conduct Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
h.	High blood pressure	NO <input type="checkbox"/>	YES <input type="checkbox"/>	x.	Traumatic Brain Injury	NO <input type="checkbox"/>	YES <input type="checkbox"/>
i.	Kidney, bladder, or urinary problems	NO <input type="checkbox"/>	YES <input type="checkbox"/>	y.	Bipolar Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
j.	Speech problem (e.g., stuttering, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	z.	Anti-Social Personality Disorder	NO <input type="checkbox"/>	YES <input type="checkbox"/>
k.	Tuberculosis (TB) or positive TB skin test	NO <input type="checkbox"/>	YES <input type="checkbox"/>	aa.	Pervasive Developmental Disorders (i.e., Asperger's or Autism)	NO <input type="checkbox"/>	YES <input type="checkbox"/>
l.	Ulcer of stomach or intestines	NO <input type="checkbox"/>	YES <input type="checkbox"/>	bb.	A mental health problem or concern	NO <input type="checkbox"/>	YES <input type="checkbox"/>
m.	Epilepsy, seizures, convulsions	NO <input type="checkbox"/>	YES <input type="checkbox"/>	cc.	A drug or alcohol problem or concern	NO <input type="checkbox"/>	YES <input type="checkbox"/>
n.	Learning disabilities (e.g., dyslexia, etc.)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	dd.	Other health problems or concerns	NO <input type="checkbox"/>	YES <input type="checkbox"/>
o.	Attention Deficit/Hyperactive Disorder (ADD or AD/HD)	NO <input type="checkbox"/>	YES <input type="checkbox"/>	ee.	FEMALES: Are you pregnant? If YES, approximate date last menstrual period began.	NO <input type="checkbox"/>	YES <input type="checkbox"/>
p.	Hepatitis	NO <input type="checkbox"/>	YES <input type="checkbox"/>				

- 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 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 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).