



U.S. Department of Labor
 Employment and Training Administration
 Office of Job Corps

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Job Corps Health Questionnaire

Applicant Name: Smith, John A.
Applicant ID: 123456
Admissions Representative: Johnson, Monica
Admissions Representative Phone Number: 202-555-5555
Admissions Representative E-mail Address: johnson.monica@jobcorps.org

Complete and sign this health questionnaire. Job Corps will use this information to make sure they can meet your healthcare needs throughout your time at Job Corps. Job Corps provides basic medical, mental health, dental, and substance use prevention services. Medical professionals review students’ health information to protect the health and safety of everyone at Job Corps.

- Part 1 of this form provides Job Corps with the health information needed to prepare for your arrival.
- Part 2 of this form must be signed by you. It must also be signed by your parent or guardian if you are under the age of 18. Your signatures authorize Job Corps to provide you with basic healthcare services.

Instructions

1. Read the entire form and answer the questions as best as you can. Some questions require an explanation.
2. Sign and date the form. If you are under 18 years old, your parent/guardian must sign and date the form as well.
3. Return your signed form to your Admissions Representative.

IMPORTANT

- Your answers help Job Corps meet your needs. However, you do not have to answer each question if you are not comfortable doing so.
- Health and disability information is private. It is stored separately from your other personal information and is only shared if required by the Department of Labor’s regulations and other applicable Federal laws.
- If you have any questions regarding the Job Corps Health Questionnaire, please contact your Admissions Representative.

Part 1: Health Information

Answer the questions below to the best of your knowledge.

Personal Information	
Legal Name (Last, First, Middle): Smith, Jonathan Andrew	Preferred Name: John
Date of Birth (mm/dd/year): 07/01/2022	

Sex Assigned at Birth (Federal law mandates that we collect data on the sex of all applicants.)

Female

Male

Other

Gender Identity

- Man Woman Transgender man Transgender woman Nonbinary
 Genderqueer or gender nonconforming Prefer not to say
 My gender identity is not listed, please specify: _____

Pronouns

- She/Her/Hers He/Him/His They/Them/Theirs
 Just use my first name Other _____

Health Insurance

Do you have health insurance? If yes, please attach a copy of the health insurance card to this form.

- No Yes I don't know

General Health Information

Answer the questions below to the best of your knowledge. Some questions require an explanation. If the question does not apply to you, check "N/A."

1. How would you describe your general health?

- Excellent Good Fair Poor

If "Fair" or "Poor," explain:

2a. Have you been prescribed any medications for a health problem in the past 12 months?

- No Yes

If yes, list the medication(s) below:

2b. If you answered "yes" to question 2a, are you still taking the medication?

- No Yes N/A

2c. If you answered "no" to question 2b, why did you stop taking the medication?

- Provider told me to stop Could not afford medication Unable to renew prescription

Didn't like how it made me feel Other _____

3. Have you taken any non-prescription medication, herbs, supplements, vitamins, etc. in the past 12 months?

- No Yes

If yes, list the medication(s) below:

4. Do you use equipment (e.g., wheelchair) or receive help getting around?

- No Yes

If yes, explain:

5. Do you need help with any of the following activities: bathing, getting dressed, eating, or managing medications?

- No Yes

If yes, explain:

6. Do you have any known allergies (e.g., medication, food, seasonal etc.)? If yes, list below:

- No Yes

If yes, list below:

Medical Health Information

Answer the questions below to the best of your knowledge. "Yes" answers require an explanation in line with the question. If the question does not apply to you, check "N/A."

1a. Have you seen a medical provider (e.g., physician or doctor, nurse practitioner, chiropractor, naturopath) in the past 12 months?

No Yes

If yes, please explain:

1b. If you answered "yes" to the previous question, how often do you see the medical provider mentioned above?

Weekly Monthly Yearly Other _____ N/A

2. Have you been told by a medical professional (e.g., doctor) that you have a health concern that needs treatment or follow-up in the past 12 months?

No Yes

If yes, explain:

3. Have you been hospitalized or treated in an emergency room or urgent care clinic for medical reasons in the past 12 months?

No Yes

If yes, explain:

Check all the medical or health conditions that may apply to you. Provide an explanation in the space provided.

<input type="checkbox"/> Anemia (including sickle cell disease)	<input type="checkbox"/> Muscle or bone disorder
<input type="checkbox"/> Asthma or other lung condition	<input type="checkbox"/> Obesity
<input type="checkbox"/> Cancer/malignancy	<input type="checkbox"/> Organ transplant
<input type="checkbox"/> Diabetes (high blood sugar)	<input type="checkbox"/> Pregnancy or pregnancy-related medical conditions
<input type="checkbox"/> Epilepsy, seizures, convulsions	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Hearing impairment/trouble hearing	<input type="checkbox"/> Speech problem (e.g., stuttering, etc.)
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Tuberculosis (TB) or positive TB test
<input type="checkbox"/> Hepatitis or other liver condition	<input type="checkbox"/> Ulcer of stomach or intestines or colitis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Visual impairment/trouble seeing
<input type="checkbox"/> Immune system problem (e.g., HIV or autoimmune disorder)	<input type="checkbox"/> Other health problems or concerns: _____
<input type="checkbox"/> Kidney, bladder, or urinary problems	

If you checked any item above, please explain:

Oral Health Information

Answer the questions below to the best of your knowledge. "Yes" answers require an explanation in line with the question. If the question does not apply to you, check "N/A."

1a. Have you seen a dental provider (e.g., dentist, orthodontist, periodontist) in the past 12 months?

No Yes

If yes, please explain:

1b. If you answered "yes" to the previous question, how often do you see the dental provider mentioned above?

Weekly Monthly Yearly Other _____ N/A

2. Do you wear attached braces (e.g., brackets and wires) on your teeth (not including retainers or aligners)?

No Yes

If yes, explain:

3. Have you had a serious dental problem or problems (e.g., swelling, untreated dental infections, several missing teeth, unresolved severe toothaches, etc.) in the past 12 months?

No Yes

If yes, explain:

Behavioral and Emotional Health Information

Answer the questions to the best of your knowledge. "Yes" answers require an explanation in line with the question. If the question does not apply to you check "N/A".

1a. Have you seen a counselor or received counseling treatment for a mental health issue in the past 12 months?

No Yes

If yes, explain:

1b. If you answered "yes" to the previous question, how often do you see the counselor mentioned above?

Weekly Monthly Yearly Other _____ N/A

2a. Have you seen a counselor or received counseling treatment for drug/alcohol use in the past 12 months?

No Yes

If yes, explain:

2b. If you answered "yes" to the previous question, how often do you see the counselor mentioned above?

Weekly Monthly Yearly Other _____ N/A

3. Have you been hospitalized or treated in an emergency room or urgent care clinic for mental health or substance use reasons in the past 12 months?

No Yes

If yes, explain:

4. Have you attempted to hurt yourself (e.g., cut yourself, deliberately overdosed on medication or other drugs) in the past 12 months?

No Yes

If yes, explain:

5. Have you thought about hurting yourself or planned to hurt yourself in the past 12 months?

No Yes

If yes, explain:

6. Have you intentionally tried to hurt someone else in the past 12 months?

No Yes

If yes, explain:

7. Have you been afraid that others want to physically harm you in the past 12 months?

<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:
8. Have you heard voices or seen things that other people did not hear or see in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:
9. Have you believed that your thoughts were being controlled by someone or something other than yourself in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:
10. Have you lost control of your anger, or feared losing control of your anger, to the point of hurting yourself or someone else in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:
11. Have you been in a physical fight that resulted in hospitalization or significant injury to you or the other person in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:
12. Have you ever (not just within the past 12 months) been asked to permanently leave any of the following places for a medical, behavioral, or mental health reason (check all that apply)? <input type="checkbox"/> No <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Job <input type="checkbox"/> Military If yes, explain:

Check all the behavioral and emotional health conditions that may apply to you. Provide an explanation in the space provided.	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADD or AD/HD)	<input type="checkbox"/> Obsessive-Compulsive Disorder (OCD)
<input type="checkbox"/> Autism Spectrum Disorders (i.e., Asperger's or Autism)	<input type="checkbox"/> Oppositional Defiant Disorder (ODD)
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Personality Disorder (e.g., anti-social, borderline, etc.)
<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)
<input type="checkbox"/> Depression	<input type="checkbox"/> Panic Disorder
<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Schizophrenia or other Psychotic Disorders
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Substance Use Disorder (e.g., alcohol, cannabis, etc.)
<input type="checkbox"/> Intermittent Explosive Disorder	<input type="checkbox"/> Other substance use problems or concerns: _____
<input type="checkbox"/> Other mental health problems or concerns:	
If you checked any item above, please explain:	

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.

APPLICANT SIGNATURE:**DATE:**

Sign

Date Signed

**PARENT OR LEGAL GUARDIAN SIGNATURE (if applicant offered enrollment is a minor):****DATE:**

Sign

Date Signed

**Part 2: Job Corps Health Services and Authorization to Administer Healthcare**

Read, sign, and date this form. It must also be signed by your parent or guardian if you are under the age of 18. Your signatures authorize Job Corps to provide you with basic healthcare services. Failure to sign this form may result in you being denied enrollment in Job Corps.

Job Corps Health Services

1. I (we) understand that Job Corps provides entrance health screening, including an entrance medical examination, CDC-recommended immunizations, mandatory tuberculosis testing, mandatory screening for use of controlled substances, and dental readiness inspection and elective oral health exam as described in Chapter 2.3 of the Job Corps Policy and Requirements Handbook
2. I (we) understand the reasons for the medical and oral examinations and laboratory testing and have had the opportunity to ask questions.
3. I (we) understand that the following are grounds for separation from Job Corps: a) refusal to provide the entry Urine Drug Screen, b) refusal to provide the follow-up Urine Drug Screen if the entry drug screen is positive, c) refusal to be tested for tuberculosis.
4. I (we) understand that Job Corps provides emergency and basic health care services as described in Exhibit 2-4 of the Job Corps Policy and Requirements Handbook.

Authorization to Receive Records and Administer Healthcare

5. I (we) authorize Job Corps to obtain any records regarding immunizations/vaccinations.
6. I (we) authorize Job Corps to receive from medical 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 of this form to which a "yes" response has been provided, if such information is deemed necessary by a center medical professional. This information may be written or verbal. I understand that this form does not authorize Job Corps to ask for any records regarding any other health conditions except for immunization/vaccination. 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/they need a specific type of extra supports (known as reasonable accommodations) to participate in Job Corps; (3) whether he/she/they have a health condition that would pose a direct threat to others if he/she/they participate in Job Corps; and (4) whether he/she/they have health care needs beyond the basic health care services provided by Job Corps. 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.
7. I (we) authorize Job Corps to provide the above-named individual with an ENTRANCE MEDICAL EXAMINATION that includes offering age-appropriate screening tests per professional medical guidelines as listed in the Job Corps Policy and Requirements Handbook.
8. I (we) authorize Job Corps to provide the above-named individual with IMMUNIZATIONS that are currently recommended by the Centers for Disease Control and Prevention in accordance with the Job Corps Policy and Requirements Handbook.
9. I (we) authorize Job Corps to administer a tuberculin skin test or blood test for tuberculosis to the above-named individual.
10. I (we) authorize Job Corps to provide the above-named individual with screening for the unlawful

use of controlled substances in accordance with the Job Corps Policy and Requirements Handbook.

11. 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.
12. I (we) authorize Job Corps to provide the above-named individual with emergency and 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.
13. 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, and public health recommended screening or treatment while he/she/they 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.
14. I (we) authorize Job Corps to offer self-selected over-the-counter medications to use as directed or as prescribed by a clinician and authorize Job Corps to provide prescribed medications under basic routine health care.

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).

APPLICANT SIGNATURE:



DATE:

Date Signed

PARENT OR LEGAL GUARDIAN SIGNATURE (if applicant offered enrollment is a minor):



DATE:

Date Signed

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 15 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 or email at ETA-PRA@dol.gov (OMB Control No. 1205-0033).