

# HR-HQ



## Gadsden County School Board

Elijah Key-Superintendent of Schools

"Putting Children First"

### Health Questionnaire

(Please print)

<b>NAME:</b>	<b>DATE OF BIRTH:</b>	
<b>ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>PHONE #:</b>	<b>SECONDARY #:</b>	

### Personal Information

Sex  Male  Female    Height \_\_\_\_\_    Weight \_\_\_\_\_    Blood Type \_\_\_\_\_

### Questionnaire

Please check any that apply. Include any additional information in the section provided below.

Do you or have you ever had:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Epilepsy                           | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Amputation(s)      | <input type="checkbox"/> Cardiac Disease (Heart Condition) |
| <input type="checkbox"/> Loss of Sight                      | <input type="checkbox"/> Poliomyelitis     | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Multiple Sclerosis                |
| <input type="checkbox"/> Parkinson's Disease                | <input type="checkbox"/> Vascular Disorder | <input type="checkbox"/> Hemophilia         | <input type="checkbox"/> Psychoneurotic Disorder           |
| <input type="checkbox"/> Ankylosis (Stiffness of the joint) | <input type="checkbox"/> Hypoglycemia      | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Chronic Osteomyelitis             |
| <input type="checkbox"/> Muscular Dystrophy                 | <input type="checkbox"/> Total Deafness    | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Surgically removed vertebral disc |
| <input type="checkbox"/> Thrombophlebitis                   | <input type="checkbox"/> Allergies         | <input type="checkbox"/> Hay Fever          | <input type="checkbox"/> Mental Retardation                |
| <input type="checkbox"/> Skin Disorder                      | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Kidney/Bladder Disorder           |
| <input type="checkbox"/> Ulcer(s)                           | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Varicose Veins/Leg Ulcer          |
| <input type="checkbox"/> Physical Impairment                | <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Knee Injury        | <input type="checkbox"/> High Blood Pressure               |
| <input type="checkbox"/> Neck/Back Injury                   | <input type="checkbox"/> Head Injury       | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Vertigo                           |
| <input type="checkbox"/> Other _____                        |  |   |  |

Are you unable to perform certain body motions or assume certain body positions?  Yes  No

Do you wear  Glasses  Contact Lenses

Have you ever had to state claim for industrial injury?  Yes  No

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Date of last examination? (Include physician name)

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**Signature**

All statements in this application are true and accurate. I agree that any purposeful omission or false statements will be constitute grounds for immediate dismissal. I also understand that unless this application is completed in detail it will not be considered. I authorize GCSB to conduct a thorough background check to include, but not limited to, criminal history records.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_