PHYSICAL AND EMOTIONAL HEALTH ASSESSMENT

TO BE COMPLETED BY STUDENT

Last Name	First Name	Middle Name	Date Of Birth	SS#

Address	City	State & Zip

Phone (Home)	Alternate Phone	Email

Associate of Science	Medical Assistant	Nursing (AND)	Nursing (BSN)
Surgical Technology	☐ Medical Imaging	Pharmacy Technology	
Occupational Therapy Assistant		Health Services Leadership & Management (HSLM)	

Program — Start Date (MM/YYYY)

TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

To be completed by healthcare provider: Please read the essential functions of the college that your patient is entering and answer the questions below based on your assessment.

Essential Functions of the Cabarrus College of Health Sciences Degree and Diploma Students

1. Critical thinking ability sufficient for clinical and/or fieldwork judgment; ability to organize responsibilities, make decisions and analyze data or reports.
2. Interpersonal abilities sufficient to interact with individuals, families, and groups form a variety of social, emotional, cultural and intellectual backgrounds.
3. Communication abilities sufficient for interaction with others in verbal and written form
4. 4. Physical abilities sufficient to move from room to room and maneuver in small places, and stand, walk or sit for extensive periods of time.
5. Gross and fine motor abilities to provide safe and effective care. Full range body motion.
6. Auditory ability sufficient to monitor and assess health needs.
7. Visual ability sufficient for observation and assessment.
8. Tactile ability sufficient for physical assessment.
9. Physical ability to lift and manipulate and/or move 45-50 pounds daily.
10. Cognitive abilities with orientation to time, place and person, ability to focus on problems and prioritize average or above intellectual functioning.

	To the Best of Your Knowledge:	
Yes No	Is the student able to perform the essential function identified above without reasonable accommodations?	If no, please explain. If reasonable accommodations are required please explain. Attach additional paper if necessary.
Yes No	Does this student have any disease or disorder of physical or emotional nature that could affect the safety of the client, fellow classmates, faculty, staff or himself/herself in the classroom, clinical or fieldwork setting?	If yes, please explain:
Yes No	Is the student now taking any prescribed medications?	If yes, please explain:
Yes No	Are there any additional physical or emotional factors, which you believe the college should be aware?	If yes, please explain:

Please **Print**:
Name of Healthcare Provider: _____ Title: _____

Practice/Agency: _____

Address: _____

Phone: _____ Length of Time You Have Known the Student: _____

Relationship to Student: ☐ Regular Healthcare Provider ☐ Urgent Care Provider ☐ Friend/Acquaintance ☐ Other

_____

Signature of Healthcare Provider — Title — Date

STATEMENT OF HEALTH INSURANCE

I have been presented information regarding my requirement and responsibility to have health insurance coverage while participating in the programs of study at Cabarrus College of Health Sciences. I understand the risks involved in working with patients/clients in clinical settings and medical and/or laboratory equipment.

My current health insurance provider: _____

Policy Holder's Name: _____ Policy Holder's Employer: _____

Policy Number: _____ Group Number: _____

Insurance Company Address: _____

City State Zip

Insurance Company's Phone Number: _____

Updating Records

The above information is accurate. In the event that I change health insurance programs or no longer carry health insurance, I understand it is my responsibility to notify the college office. I further understand that if I do not report any changes in my insurance status I may face disciplinary action up to and including termination from the program and/or college.

Please attach a copy of your current insurance card. It is the student's responsibility to provide an updated copy of this card each year to the college office or when your provider information changes.

Name – Please Print	Program
Signature	Date
Witness Signature	Date

Attach copy of current insurance card.

CONSENT FOR TREATMENT OF MINOR STUDENT

I hereby authorize CMC-NorthEast, its employees or agents, and any member of its Medical staff to provide medical treatment needed by _____ (name of minor) as a result of any condition, injury or illness occurring while a student at Cabarrus College of Health Sciences.

_____ Signature of Parent or Guardian/Date

_____ Witness (NOT A RELATIVE)/Date

NOTE: Parents or Guardians of Minors – NC Law recognizes one's adulthood and age of responsibility as 18 years of age.

CABARRUS COLLEGE of HEALTH SCIENCES

STUDENT INFORMATION SHEET

PLEASE PRINT CLEARLY:

Program/Course/Position:				Date	
Last Name	First			M.I.	
Street Address				Apartment/Unit #	
City	State	ZIP		County of Residence	
Home Phone	E-mail Address			Date of Birth	
Work Phone		Cell Phone		SS No.	
Current Employer					

TO BE NOTIFIED IN CASE OF EMERGENCY

Contact #1		Relationship	
Address			
Home Phone	Cell Phone	Work Phone	
Contact #2		Relationship	
Address			
Home Phone	Cell Phone	Work Phone	

STUDENT SECTION

NEWS RELEASE INFORMATION

(CCHS DEGREE OR DIPLOMA STUDENTS ONLY—IMPORTANT FOR HONOR LISTINGS, GRADUATION, ETC.)

Name of Newspaper	
Mailing Address	
I would like my information to appear as (please include hometown):	
	Example: Jane S. Doe-Concord, NC

PARKING REGISTRATION

Two FREE permits are issued per student. You must list information for all vehicles that you may drive on campus. Additional permits are available for $5. Place permit in lower left hand side of the rear glass. ***Failure to display permit will result in parking fines.*** Please refer to the *Cabarrus College Student Handbook* for additional parking rules.

Student/Employee's Driver's License #	State
Make & Model of **Vehicle #1**	Color
License Plate #	State
Registered Owner	
Make & Model of **Vehicle #2**	Color
License Plate #	State
Registered Owner	

DEMOGRAPHIC INFORMATION

(CCHS students only) This information is requested by the U.S. Department of Education and is used for statistical purposes ONLY:

Gender: M☐ F☐	Ethnic Group: ☐ Hispanics of any race For non-Hispanics only: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Two or more races_____

To participate in SonisWeb's text messaging emergency notification system, please provide your cell phone number and provider when you update our biographic information in SonisWeb. I understand standard text rates may be charged to my cell phone provider. One test will occur each term.

I hereby certify that the above information is correct. I also understand that it is my responsibility to keep this information current with the College office.

I also give Cabarrus College my permission to release information about my participation in activities, honors and awards to the local media and/or the newspaper indicated on this form.

Signature	Date

FOR SECURITY USE ONLY

Decal # Vehicle #1	Date of Issuance
Decal # Vehicle #2	Date of Issuance
Parking Lot-CCHS	Name of Responsible Person Assigning Decal(s)