STATEMENT OF HEALTH FORM

NAME: (Please Print)___________________________________ Phone Number _______________

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Address

____
City, State, Zip

Social Security Number _____________________ Birth Date _________________

Please answer the following questions by entering an "X" on the appropriate line for each question.

During the last year have you had any disabling chronic conditions, physical, mental emotional illness requiring care of a physician, psychologist, or any other profession? ____Yes ____No

Do you suffer for any physical or mental limitations which might affect your ability to provide care?
____Yes ____No

Are you currently diagnosed, receiving therapy or medication for a mental health problem which might affect your ability to provide care? ____Yes ____No

Have you received counseling or treatment related to chemical dependency on drugs or alcohol within the past year?
____Yes ____No

Have you ever been addicted to drugs and/or alcohol or been treated for drugs and/or alcohol abuse within the past three years? ____Yes ____No

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Emergency Contact Information: Name ____________________________ _____________________
Relation

_____________________ ____
Number Address

PLEASE READ, THEN SIGN AND DATE:

I understand this information is confidential and is to be used only by J&J Healthcare Institute. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my school participation. I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge.

Signature____ Date _____________