

SANTA CRUZ COUNTY HEALTH QUESTIONNAIRE

Class Title:

Department:

Name:

Social Security No.:

TO BE COMPLETED BY CANDIDATE:

Birthdate Sex Height Current Weight

Have you had any unexpected weight change in the past year? ___ Yes ___ No

Have you had any medical tests or examinations in the past three years that relate to your ability to perform the job for which you applied? ___ Yes ___ No

If yes, state specifics: _____

Name(s) of doctor(s) who provided the examination(s): _____

Do you have ANY physical or mental problems that might not let you work safely or might limit your ability to perform certain types of work, or any problems which might cause you health problems in carrying out your work? ___ Yes ___ No

If yes, what are they? _____

Do you have any trouble:

If "Yes," please explain:

- | | | | |
|---|---------|--------|-------|
| Lifting? | Yes ___ | No ___ | _____ |
| Bending? | Yes ___ | No ___ | _____ |
| Stooping? | Yes ___ | No ___ | _____ |
| Kneeling? | Yes ___ | No ___ | _____ |
| Crawling? | Yes ___ | No ___ | _____ |
| Pushing? | Yes ___ | No ___ | _____ |
| Pulling? | Yes ___ | No ___ | _____ |
| Standing? | Yes ___ | No ___ | _____ |
| Sitting? | Yes ___ | No ___ | _____ |
| Breathing? | Yes ___ | No ___ | _____ |
| Typing? | Yes ___ | No ___ | _____ |
| Reaching above
shoulder height? | Yes ___ | No ___ | _____ |
| Walking? | Yes ___ | No ___ | _____ |
| Working in a fast
paced or stressful
environment? | Yes ___ | No ___ | _____ |

Have you ever had any skin problems or diseases, such as rashes, allergies, blisters, or dried or chapped skin from prior work in a job similar to the one you're applying for now?

Yes ___ No ___ If "Yes," please explain: _____

Do you have or use a hearing aid? Yes ___ No ___

Do you have any trouble hearing? Yes ___ No ___

If "Yes," please explain: _____

Do you wear corrective lenses? Yes: ___ glasses ___ contacts No ___

Do you have any problems seeing or other vision problems? Yes ___ No ___

If "Yes," please explain: _____

What medicine or prescriptions are you taking now? _____

CERTIFICATION: I declare under penalty of perjury under the laws of the State of California that I have provided true and complete information to the above questions. I understand that omissions or misrepresentations may result in a bar to my employment or removal from employment.

Date: _____ Candidate's Signature: _____

We request your permission to obtain your medical records from any licensed physician or other licensed practitioners you have seen, or any hospital, clinic or other medical facility, which might have records of any treatment or care provided for you during the past three years that relate to your ability to perform the job for which you have applied. To give us that permission, please complete the attached authorization form.

NOTE: If you are under age 18, you must have a signed release from your parent or guardian for the post-job offer physical examination. See attached authorization form.

Authorization for Release of Medical Information

To any licensed physician, other licensed practitioner, hospital or clinic, medical related facility or workers' compensation administrator which is in possession of medical records pertaining to:

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

In order to assist Santa Cruz County to determine my eligibility for employment with the County of Santa Cruz, I authorize you to copy and to transmit to the medical office listed below, any and all data and records concerning my physical and mental health for the three years before the date that this release is executed. This authorization expires 180 days after the date executed.

MEDICAL SERVICES DIRECTOR
County of Santa Cruz
1080 Emeline Street
P.O. Box 962
Santa Cruz, CA 95061

CANDIDATE'S SIGNATURE

DATE

Candidates may receive a copy of this Authorization upon request.

FOR CANDIDATES UNDER AGE 18

MEDICAL RELEASE FOR PRE-EMPLOYMENT PHYSICAL EXAMINATION

Candidate's Name (Last, First, Middle)

This is to certify that I am the parent or guardian of the job candidate listed above, and that I do hereby consent to the performance of a pre-employment physical examination of the candidate. I understand that this physical examination is not for diagnostic or treatment purposes, and that the candidate and I should not rely upon passing the examination as proof that the candidate is in good health or free from disease. I also understand that the results of this examination may not be used as a substitute for examinations for other purposes such as insurance coverage or licensure.

Name of Parent or Guardian (Please PRINT)

Date

Signature of Parent or Guardian

Relationship to Applicant

PER 1025A Rev. 9/23/03