Jay College of Health Sciences Application Form

Our Campus Location:
5275 Babcock St NE Palm Bay, FL 32905
(301) 844-5125 (301)335-4265

Please select your program of choice:

☐**licensed practical nurse (LPN)**

☐**Bachelor of Science in Nursing (BSN)**

Print clearly:

☐**Mr.** ☐**Mrs.** ☐**Ms.** ☐**Miss** ____

Last Name First Name Middle Name

Address:____

Number and Street City/Town State Zip

Phone Number (area code, number): ______________________ ______________________

____

Home Work/Cell

Date of Birth:_____/_________/_________

Gender: ☐ Female ☐ Male

U.S. Citizen:

☐ Yes ☐ No

High school/Institution where GED was obtained: ____

Address: ____ Year of Graduation/GED Completion:

City State Zip

Race/Ethnicity:

☐ Hispanic/Latino
☐ American Indian
☐ Native Hawaiian or other Pacific Islander
☐ Other
☐ White
☐ Asian
☐ Black/African American

This information is optional and sought solely for accreditation reporting purposes. Jay College Health Science has adopted privacy policies and practices designed to protect student's personal information. The information collected is only disclosed as permitted under the Family Educational Rights and Privacy Act of 1974 as amended (FERPA). The FERPA policy is printed in the student handbook and is available for review in the Student Services office.

Previous Education: Please list all post-secondary institutions previously attended.

Name of Institution	City/State	Dates Attended	Credential Earned

Current Employer:____Position/Title: __________________________

I certify that the information provided on this application is complete and accurate. I realize that failure to provide correct information is sufficient cause for reconsideration of my admission status.

Signature:____Date:________/________/__________

Jay College of Health Sciences, INC.

5275 Babcock Street NE Palm Bay, FL 32905

Physical Assessment

Name: ______________________________ Date: _______________

Address: _________________________________ City: __________________

State: _______ Zip: ______________ Phone Number:_______________________

Date of Birth: (Please Circle) (F) Female (M) Male

Please Note: This health assessment must be completed by an MD, DO, PA, or ARPN.

Physical Assessment

Height: ______________ Weight: ______ Temperature: _______

Vital Signs:________ BP _______ P _____ R _______

Visual Acuities: R ____ L ________

Uses Eyeglasses: YES NO Uses Contact Lenses: YES NO

Hearing Acuities: R ______ L ______ Uses hearing Aid: YES NO

Immunization Records

MMR Date: ____________________ Hepatitis Series (1) Date: ___________________________

Varicella Date ________________________ (2) Date: ___________________________

Tetanus Diphtheria (TD) Date: ____________________ (3) Date: ___________________________

Medical History

Circle Yes or No

Allergies	Yes	No	If YES Explain: ________________________________
Major illness	Yes	No	If YES Explain: ________________________________
Hospitalizations	Yes	No	If YES Explain: ________________________________
Orthopedic Problems	Yes	No	If YES Explain: ________________________________
Major Surgeries	Yes	No	If YES Explain: ________________________________
Heart Problems	Yes	No	If YES Explain: ________________________________
Lung Problems	Yes	No	If YES Explain: ________________________________
Abdominal Problems	Yes	No	If YES Explain: ________________________________
Mental Health Illness	Yes	No	If YES Explain: ________________________________
Current Medication	Yes	No	If YES Explain: ________________________________

Physical Assessment (Continued)

Skin			
HEENT			
Heart			
Lungs			
Abdomen			
Musculoskeletal			
Neurological			

THE FOLLOWING DIAGNOSTIC TEST ARE **REQUIRED**

Please attach copy of all lab results

TITERS	DATE	IMMUNE	NON-IMMUNE
Measles			
Rubella			
Rubeola			
Varicella			
Hepatitis B			
Tetanus			
Flu Vaccine			

	DATE	NORMAL FINDING	ABNORMAL FINDINGS
Urinalysis: 10 Panel Drug Screen			
*PPD			
Chest X-ray if history of positive PPD			

**if PPD is positive the student must provide documentation of a negative chest x-ray taken within the last 12 months or documentation as a previous positive reactor and written medical clearance from any active chest disease.*