



6. Do you have any limitations or restrictions in the following area? Please describe.

a. Lifting up to 60 pounds?

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b. Reaching, handling, feeling, manual dexterity?

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c. Speaking and hearing, as in a classroom, or when using a stethoscope?

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d. Seeing clearly, as in reading thermometers or gauges?

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e. Standing and sitting equally for two hours at a time?

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It is the policy of Columbus State Community College not to discriminate against any individual or groups of individuals in the College's programs or policies. This assurance of non-discrimination shall include applicants for employment or academic admission, students, and employees, and shall be applied regardless of race, color, gender, age, religion, ancestry, national origin, disability, or veteran status.

*I certify that no information regarding my health history has willfully been omitted and that to the best of my knowledge, recollection, and belief, the information I have given on this record is an accurate and complete account of my health history. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change in any way (e.g. surgery, pregnancy, injury, new medical diagnoses) during the course of my studies at Columbus State, I must report these changes in my health to the College Health Office. I understand that immunization records, titer results, and tuberculin testing information may be released to hospitals or other health facilities upon their request, prior and pursuant to my affiliation with them. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks, or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.*

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**(Date)**

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**(Student Signature)**

WAIVER FOR HEPATITIS B IMMUNIZATION

NAME: \_\_\_\_\_

SS#: \_\_\_\_\_

I understand that due to my educational or occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I also understand or have had explained to me that Hepatitis B is a very serious infection of the liver which can cause me significant illness or death. I understand that if I become infected with Hepatitis B, I can infect others through blood-to-blood contact or through sexual contact. I understand that the Hepatitis B immunization could protect me from the Hepatitis B infection.

Despite knowing this, I request a waiver from the Hepatitis B immunization requirement. In choosing not to receive the Hepatitis B immunization, I understand that I continue to be at risk of acquiring Hepatitis B infection. Should I become infected with Hepatitis B during my studies or employment, I will not hold Columbus State Community College or any of its associates or affiliates liable for any consequences in perpetuity.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

TECHNOLOGY/DEPARTMENT: \_\_\_\_\_

WITNESS: \_\_\_\_\_