TRUMAN STATE UNIVERSITY
Health Information Form (Science Division)

Course _____ Lab Day & Time _____ Instructor _____

Laboratory Room Number _____

Name _____ D.O.B. _____

Local Address and Phone _____

Permanent Address _____

Name and Phone of a Contact Person(parent/ guardian) _____

Name and Address of Family Physician _____

Allergies _____

Current Medications _____

Date of Last Tetanus Immunization _____ Contact Wearer (select one) Y☐ N☐

Check any of the following conditions that apply to your medical history:

- ☐ Heart Trouble (e. g., arrhythmia, murmur, defect)
- ☐ High Blood Pressure
- ☐ Clotting Disorders (e. g., hemophilia)
- ☐ Breathing Disorders (e. g., chronic bronchitis, CF)
- ☐ Asthma
- ☐ Fainting/Dizzy Spells
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Other (list below)

Other Conditions:_____

Past Surgical History: _____

This health form is for <u>emergency use only</u>. It will be provided to you and the EMT's, if you seek medical care. Your medical treatment is dependent on the information that you provided. By 10 days after the final exam week of the semester, the form will be shredded.

Date_____ **Signature**_____

LAB USE ONLY **<u>Chemical Exposure Information</u>** **LAB USE ONLY**

Chemical exposed to _____

When exposure occurred _____ Approx. amount present at exposure _____

Treatment Provided in Lab _____

_____

MSDS to Hospital (circle one) Y N

Revised July 30, 2004