Department of Life Sciences Field Trip Medical Data Form

(The following information is requested to help provide appropriate medical services. Please complete in full)

☐ **Tick here if you have any condition(s) that you believe may affect your health on a field trip, and mark them below (*)**

Student Information

NAME (Last, First, Middle):_____

Date of Birth:_____ Sex:(circle one) Female or Male

Age:_____

Permanent Home Address: Telephone Number:_____-_____

Number and Street: _____

_____ Cell Phone:_____-_____

Personal Medical History

Have you ever been diagnosed by a medical doctor or counselor with any of the following conditions? (mark X)

____ Alcohol/Drug abuse ____ Asthma ____ Diabetes ____ Eating Disorder

____ Hayfever ____ Heart Disease ____ Hepatitis ____ High Blood Pressure

____ Kidney Disease ____ Gynecological Problems ____ Migraine Headaches ____ Seizures

____ Pneumonia ____ Rheumatic Fever ____ Thyroid Trouble ____ Tuberculosis

____ Ulcers ____ Emotional/Behavioral Disorders (including phobias)

Other (state condition) _____

Surgery: Please list any surgeries you have had._____

Disabilities Do you have any of the following disabilities? (mark X)

____ Amputation or Permanent Impairment ____ Hearing Impairment

____ Speech or Voice Impairment ____ Vision. If so, is it corrected?_____

____ Permanently confined to wheelchair ____ Learning Disabilities. Specify_____

Other Impairments. Specify_____

Allergies Are you Allergic to any Serum, Drug or Medicine (penicillin, antitoxin, etc.)?

__Yes __ No If yes, specify_____

Do you have any other allergies? __ Yes __ No

If yes, specify_____

Medications Are you taking any maintenance medications or are you currently receiving other medical treatment? __ Yes __ No If yes, specify_____

In case of Emergency

Parent's or Guardian's Information

Name:_____

Home telephone number :_____-_____ Work telephone number: _____-_____

Cell Phone _____-_____ Place of work:_____

Emergency contact (In case parent or guardian cannot be reached)

Name:_____ Telephone number:_____-_____

Relation to you:_____

Family Physician Doctor's name:_____ telephone:_____-_____

Address:_____

Preferred emergency Center:_____

Health Insurance

Name of Insurance Company providing medical assistance:_____

Policy Number:_____ Expiration Date (if any):_____

Signature_____ Staff/Student ID_____

Semester_____ Course(s) with field trips_____.