TRUMAN STATE UNIVERSITY
Chemistry Department Health Information Form

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 (check 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 depended 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 ____

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MSDS to Hospital (circle one) Y N

Revised July 30, 2004