TRUMAN STATE UNIVERSITY **Chemistry Department Health Information Form**

Course	Lab Day & Time	Instructor
Laboratory Room Numbe	r	
Name		D.O.B
Local Address and Phone	e	
Permanent Address		
Name and Phone of a Co	ontact Person (parent/ guardian)	
Name and Address of Fa	mily 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 Heart Trouble (e. g., arrhythmia, murmur, defect) High Blood Pressure Clotting Disorders (e. g., hemophilia) Breathing Disorders (e. g., chronic bronchitis, CF) Asthma Other Conditions: Past Surgical History:		☐ Fainting/Dizzy Spells ☐ Convulsions/Seizures ☐ Diabetes ☐ Kidney Disease ☐ Other (list below)
This health form is for emerg	gency use only. It will be provided to you epended on the information that you prov	and the EMT's, if you seek medical care. Vided. By 10 days after the final exam week
Date	Signature	
LAB USE ONLY	Chemical Exposure Informa	ation LAB USE ONLY
Chemical exposed to		
When exposure occurred	Approx. amount pre	sent at exposure
Treatment Provided in La	b	