

**Field Trip Medical Questionnaire**

**Course: \_\_\_\_\_\_\_\_\_\_\_ Semester: \_\_\_\_\_\_\_\_\_\_\_ Instructor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by the participant at the start of the semester.**

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Emergency Contacts:** (Person(s) to be notified in case of emergency)

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:  | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship  |
| **I consent to TRU disclosing to the above person(s) personal information about me including medical information** |

**Medical History:**

1. Give a brief statement of your general health.

2. Do you have any present medical problems? ☐ No ☐ Yes – Describe

3. Are you taking any medications? ☐ No ☐ Yes

4. Do you require a special diet? (If vegetarian, ☐ No ☐ Yes

 list what you do not eat.)

5 Do you suffer from severe headaches, ☐ No ☐ Yes

dizziness or fainting?

6. Do you have seizures? List medications ☐ No ☐ Yes

 and dosages.

7. Are you allergic to any of the following?

 *(Please list all allergies and describe nature and severity of reaction.)*

 a. Medications ☐ No ☐ Yes – Describe

 b. Foods ☐ No ☐ Yes – Describe

 c. Insect bites ☐ No ☐ Yes – Describe

 d. Other ☐ No ☐ Yes – Describe

8. Do you carry an Epi-pen? ☐ No ☐ Yes – Why?

9. Do you have asthma? ☐ No ☐ Yes

 If yes, what triggers your asthma?

 Has it been stable for the past year? ☐ No ☐ Yes

 Do you take medication for your asthma? ☐ No ☐ Yes

10 Do you have any phobias such as claustrophobia,

 agoraphobia, acrophobia? (strong fear of confined

 spaces, open areas, heights, snakes) ☐ No ☐ Yes - Describe

11. Do you have problems with your neck, back, ☐ No ☐ Yes - Describe

 arms, ankles or knees that limit your activities?

12. Do you have diabetes, hypoglycaemia, ☐ No ☐ Yes - Describe

 thyroid trouble or other endocrine problems?

13. Do you have any other medical conditions
(other than those listed those listed)? ☐ No ☐ Yes

As a result, are there any special precautions or ☐ No ☐ Yes - Describe

procedures that may be required.?

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please Print

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read this completed form:**

Instructor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please Print

Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_