

Health and Safety Questionnaire

Withholding medical information could result in the participant’s dismissal from the program.

Preferred Name: _____

Age: _____ Female _____ Male _____ Non-Smoker _____ Smoker _____

Do you have any medical condition(s) – such as allergies, heart disease, emphysema, diabetes, seizures, depression, injuries, recent surgery, etc. – that would be important to know about in case of an emergency?
No__ Yes__ If “Yes”, please specify condition(s)

Do you have any food allergies?

Do you have any restrictions such as impaired vision, hearing, breathing, mobility, etc.?

Do you require any prescription medications on a regular basis in order to function effectively?
If “Yes”, please list the name(s) of and reason(s) for taking said medication(s) or write “NONE”:

Participant Insurance Information

Primary Care Physician: _____ Tel. Number: (____) _____ - _____

CBU reserves the right to contact your physician with questions. 24-hour emergency if available

Do you have private medical/accident/illness insurance coverage? No__ Yes __ Please specify:

Name(s) of Insurance Company(s) and Policy Number(s): -

Please understand that inaccurate answers or omissions of any information requested above could result in harm to you or your fellow program participants.

Signed: _____ Date: _____

(Parent or legal guardian must sign this form if participant is under the age of 18)

RETURN SIGNED FORM TO:

**Dr. Emily Forsdick BU 346 or
Mrs. Wanda Anderson BU 342**