HEALTH AND EMERGENCY SERVICES

To assist us in seeing that you receive proper treatment for any illnesses or injury that might occur during your training at the Academy we must have the following information.

Name: _____ S.S.#_____
(LAST) (FIRST) (MIDDLE)

Department:_____ Department Phone:( )_____

Are you taking any medication? Yes____ No____ If yes, please list that medication and dosage:

_____.

Have you had surgery or been confined to a hospital within the past two years? Yes_____ No_____ If yes, are you still under a doctor's care for that confinement? Yes_____ No_____

Are you allergic to any foods, medication, animals, plant life, insects, etcetera? Yes_____ No_____
If yes, describe:_____

_____.

Please indicate: Heavy Smoker_____ Moderate Smoker_____ Non-Smoker_____ Use Smokeless Tobacco _____

Do you have any religious or personal convictions concerning medical treatment that you would like for us to be aware of in obtaining treatment for you? Yes_____ No_____ If yes, describe:

_____.

Do you have any special diet requirement? Yes_____ No____ Describe: _____

_____.

Do you have any physical limitations, recent or old injuries that might restrict your full participation in physical activities while at the Academy? Yes_____ No_____ If yes, describe:

_____

_____.

The Academy is not authorized to pay for casts, bandages, medications, X-rays, prescriptions or visits to hospitals, doctor or dentist. Your insurance or that of your department must be used. (Over 50% of student injuries occur during leisure time, especially during athletic activities.)

Please list here your personal insurance company, policy number, and billing address:

_____.

Please list here your department's insurance company, policy number, and billing address:

_____.

If you are not covered under a personal or department insurance policy, please provide here the information necessary for a physician or hospital to bill your department under Worker's Compensation.

_____

_____.

EMERGENCY NOTIFICATION INFORMATION: NAME OF PERSON TO BE NOTIFIED IF THE ACADEMY IS TO MAKE NOTIFICATION CONCERNING INJURY OR ILLNESS

FULL NAME	RELATIONSHIP	AREA CODE	PHONE NUMBER

_____ _____
SIGNATURE OF STUDENT DATE

*The social security number of the data subject is being requested as an exchange of information between agencies, provided for by IC 4-1-6-2. Disclosure is necessary to fulfill a statutory mandate and confidentiality of the social security number will be maintained by the Law Enforcement Training Board as provided by law.

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