



*Commonwealth of Massachusetts  
Massachusetts State Police Academy  
Student Trooper Program  
Medical Status Questionnaire*

Student Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: Home: (\_\_\_\_) \_\_\_\_\_

Cell \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Health Insurance: Yes No Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Brief Medical History: (list injuries past and present)

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Allergies: Yes No (If yes, please identify)

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List all medications (both over the counter and prescribed medications) taken:

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**TWO SIDED FORM – SEE REVERSE SIDE  
PARENT SIGNATURE REQUIRED ON REVERSE SIDE**

I \_\_\_\_\_ parent/guardian of \_\_\_\_\_

(PRINT)

(PRINT)

state that the information contained on this form is true to the best of my knowledge.

I give permission to the members of the Massachusetts State Police Academy Health Unit to dispense any over the counter medication and/or prescribed medication to the above Student Trooper. Please be advised that all medications brought to the Massachusetts State Police Academy must be in it's original packaging including over the counter medicine and a pharmacy label must be on all prescribed medications.

I give permission to members of the Massachusetts State Police Academy staff and/or Health Unit to provide initial medical treatment and in the case of an emergency to have the above Student Trooper transported to the nearest medical facility and treated by a physician.

\_\_\_\_\_  
(Print Parent/Guardian Name)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)