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)

_____

_____

_____

_____

Allergies: Yes☐ No☐ (If yes, please identify)

_____

_____

_____

_____

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

_____

_____

_____

_____

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)