LOCAL/STATE/NATIONAL/INTERNATIONAL VOLUNTEER OPPORTUNITY PROGRAM
STUDENT HEALTH QUESTIONNAIRE

Student Name: _____
Student ID #: _____

Age: _____ Height: _____ Weight: _____ Blood Type: _____

1. List any dietary restrictions (e.g. you are a Vegetarian or have specific food allergies):_____
   _____
   _____
   _____

2. List any allergies (insects, food, medications). If yes, please describe any ongoing treatment required while involved with Volunteer Opportunity Program: _____
   _____
   _____
   _____

3. List any prescription **AND** non-prescription (such as aspirin, allergy pills, etc.) medications you are currently taking. Please describe your plan for continued use while involved with the Volunteer Opportunity Program: _____
   _____
   _____
   _____

4. List any recent injuries **AND/OR** illnesses: _____
   _____
   _____
   _____

5. List any physical injury, disease or psychological problems that you have been treated for within the past five years. Please describe how any current treatment might impact your ability to fully participate in this Program. _____
   _____
   _____
   _____

6. If you are currently being treated, or have you been treated in the last five years, for a mental health condition (e.g., addiction, depression, anxiety, eating disorder, or a condition related to loss or grief), you are requested to explain below and include any details regarding ongoing treatment, specifically how you plan to manage your treatment while involved in this Program. _____
   _____
   _____
   _____

7. List any other concerns that might require accommodation or would be helpful for the Program Coordinator to be aware of during your volunteer experience. _____
_____
_____
_____

8. If you have any mobility or physical activity restrictions (e.g. a disability, obesity, cardiac condition, etc.) that may require reasonable accommodations or assistance to fully participate in a Volunteer Opportunity Program, you are requested to explain below. You will need to contact Disability Services. _____
_____
_____
_____

9. If you have any health condition or disability (e.g. a disability, attention deficit disorder, diabetes, brain injury, epilepsy, etc.) that may require reasonable accommodations or assistance to fully participate in a Volunteer Opportunity Program, you are requested to explain below. You will need to contact Disability Services._____
_____
_____
_____

10. If you have a sensory or visual impairment or loss that may require reasonable accommodations or assistance to fully participate in a Volunteer Opportunity Program, you are requested to explain below. You will need to contact Disability Services._____
_____
_____
_____

11. If there is any additional information that you believe would be helpful or necessary for the Program Coordinator to be aware of prior to and/or during your participation in the Volunteer Opportunity Program, please explain and attach any relevant documentation to this form. ___
_____
_____
_____

12. Name of student's physician: _____
City: _____ State: _____
Zip Code: _____ Country: _____
Phone: (_____)_____

If any of the above information changes, please complete and submit a new form.

STUDENT HEALTH QUESTIONNAIRE SIGNATURE PAGE

If I experience a medical emergency in route to or from or while I am participating in the Quinsigamond Community College Local/State/National/international Volunteer Opportunity Program and I am rendered unconscious or incoherent, and my emergency contact (listed on my EMERGENCY CONTACT INFORMATION form) cannot readily be reached, I authorize Quinsigamond Community College to select any licensed physician to secure and administer medical treatment, including hospitalization and surgery for me if and as needed.

I understand any expense for medical treatment so incurred will be my financial responsibility. I further release Quinsigamond Community College and its trustees, officers, employees and agents, the Massachusetts Board of Higher Education and its trustees, officers, employees and agents, and the Commonwealth of Massachusetts from any liability in case of accident or injury.

I have carefully read and completed this questionnaire. I have listed above all the information concerning allergies, unusual medical history or conditions, dietary restrictions and regular medications that I take.

Student's Signature: _____
Print Name: _____
Student's Date of Birth: _____
Todays Date:_____

SIGNATURE OF PARENT(S) OR LEGAL GUARDIANS(S) REQUIRED IF STUDENT IS UNDER EIGHTEEN (18).

Signature of Parent/Guardian #1: _____
Print Name: _____
Date: _____

Signature of Parent/Guardian #2: _____
Print Name: _____
Date: _____