**MASSACHUSETTS FIREFIGHTING ACADEMY**
**Recruit Training Program Medical Questionnaire**

**Name: _____ DOB_____ Last 4 of SSN:_____**
**Home Address: _____ STATE_____ ZIP_____**
**Fire Department: _____**
**Chief of Department: _____ Telephone: _____**

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**Personal Physician: _____ Telephone: _____**
**Address: _____**
**Health Insurance Company: _____**
**Policy Number: _____ Type: _____**

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1. Do you have any allergies? Yes / No
If Yes, please list: _____

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2. Are you currently taking or do you regularly take and medication, including prescribed or over the counter medications? Yes / No
If yes, please list:_____

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3. Have you ever had a reaction to a medication? Yes / No
If yes, please describe: _____
_____

4. Do you take any vitamins, dietary or work out supplements, or comparable: Yes / No:
If yes, please list: _____
_____

5. Have you ever received a heat injury or cold weather injury? Yes / No:
If yes, please describe: _____
_____

6. Have you ever been diagnosed with Sickle Cell Disease? Yes / No_____

7. Any other new medical history / diagnosis since your Department Physical? _____
_____
_____

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**Emergency Contact Information:**

**1st Contact: _____ Relationship to you: _____**
**Address: _____**
**Primary Phone: _____ Alternate Phone: _____**
**Relationship to you: _____**
**2nd Contact: _____**
**Address: _____**
**Primary Phone: _____ Alternate Phone: _____**

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This questionnaire **will be** used to provide medical information to first responders in any instance where the student is unable to answer questions. If there are any changes lo this information while you are in the program, please ask to update your sheet.