# IRIS Undergraduate Internship Program - Participant Medical Form

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|---|---|---|---|---|
| Name: | Address: | | | |
| City: | State: | Zip: | Phone: | |
| Email Address: | Age: | | Height: | Weight: |
| Contact in case of an emergency: | Relationship: | | Emergency Contact's Phone #: | |
| Health Insurance Company: | Policy #: | | | |

Do you have any special dietary needs? _Yes _No If yes, explain: _____
_____
_____

**Please indicate if you are allergic to any of the following:**
Bee stings _Yes _No If yes, how do you react? _____
Insect Bites _Yes _No If yes, how do you react? _____
Food _Yes _No If yes, please list foods: _____
Poison Ivy _Yes _No If yes, how do you react? _____
Other Plants _Yes _No If yes, please list plants: _____
Medications _Yes _No If yes, please list medications: _____

What medications do you carry for allergic reactions?
_____
_____

Are you currently suffering from any illness, injury, physical, medical, or emotional condition that could affect your participation? _Yes _No If yes, explain: _____
_____
_____

Please list all medications you are currently taking and purpose
_____
_____
_____

**Medical History** - Do you or have you had the following conditions?
Dizziness, loss of consciousness, recurring headaches _Yes _No
Chest pain, shortness of breath, heart disease, high/low blood pressure _Yes _No
History of diabetes, hypoglycemia _Yes _No
Depression, anxiety, nervousness _Yes _No
Hernia, fracture, dislocation, sprain, injury _Yes _No
Surgeries _Yes _No
If you checked yes to any of the above, please explain:

_____
_____
_____
_____

Are you currently pregnant? _Yes _No

*I certify that this form is a complete and accurate statement of my health and that I have listed any conditions that may prevent me from fully participating. I understand that I am solely responsible for providing my own health insurance and for all medical expenses related to my participation in the IRIS Undergraduate Internship Program. In the event of a medical emergency, I grant my permission for any medical care, which might become necessary.*

Signature of Participant: _____

Date: _____