The Department of Criminal Justice Training

Medical/Safety Form

**Course Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Course Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Officer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL QUESTIONS**

1. Do you have **any** reason for not participating or reducing participation in skills training with the Department of Criminal Justice Training? NO\_\_\_\_\_ YES\_\_\_\_\_ if yes, please explain:

1. Do you have **any** health problems that should be brought to the attention of the Department of Criminal Justice Training? NO\_\_\_\_\_ YES\_\_\_\_\_ if yes, please explain:

**MEDICATIONS**

Are you currently taking any prescription or nonprescription medications that will interfere with your training NO\_\_\_\_\_ YES\_\_\_\_\_ If yes, please consult with your doctor prior to coming to class.

 SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_