Submit Form Reset Form

HEALTH AND EMERGENCY SERVICES

State Form 50937 (R2 / 1-20)
INDIANA LAW ENFORCEMENT ACADEMY
LAW ENFORCEMENT TRAINING BOARD

INSTRUCTIONS: 1. Please complete this form at home and e-mail it to MedicalDocs@ilea.IN.gov prior to reporting to the Academy.

To assist us in seeing that you receive proper treatment for any illnesses or injury that might occur during your training at the Academy, we must have the following information.

SECTION 1 - *TO BE COMPLETED BY ILEA STAFF ONLY.*

Student's last name	Student's first name	Student's middle name	Suffix

Public Safety Identification (PSID) Number	Name of department	Department telephone number ( )

Are you taking any medication(s)? ☐ Yes ☐ No

If Yes, *please list medication(s) and dosage(s).*

Have you had surgery or been confined to a hospital within the past 2 (two) years? ☐ Yes ☐ No

IF YES, are you still under a Doctor's care for that confinement? ☐ Yes ☐ No

Are you allergic to any foods, medication, animals, plant life, insects, etc.? ☐ Yes ☐ No

If Yes, *please describe.*

Please indicate: ☐ Heavy Smoker ☐ Non-Smoker ☐ Use Smokeless Tobacco

Do you have any religious or personal convictions concerning medical treatment that you would like for us to be aware of in obtaining treatment for you? ☐ Yes ☐ No

If Yes, *please describe.*

Do you have any special diet requirements? ☐ Yes ☐ No

If Yes, *please describe.*

Do you have any physical limitations, recent or old injuries that might restrict your full participation in physical activities while at the Academy? ☐ Yes ☐ No

If Yes, *please describe.*

The Academy is not authorized to pay for casts, bandages, medications, X-rays, prescriptions or visits to hospitals, doctor or dentist. **Your insurance or that of your department must be used.** (Over 50% of student injuries occur during leisure time, especially during athletic activities.)

Name of your personal insurance company	Policy number

Address of insurance company *(number and street, city, state, and ZIP code)*

Name of your department's insurance company	Policy number

Address of insurance company *(number and street, city, state, and ZIP code)*

If you are not covered under a personal or department insurance policy, please provide here the information necessary for a physician or hospital to bill your department under Worker's Compensation.

EMERGENCY NOTIFICATION INFORMATION

Provide the name of person to be notified if the academy is to make notification concerning injury or illness.

Full name of person to be notified	Relationship	Telephone number with area code ( )