SENIOR VOLUNTEER PROGRAM MEDICAL QUESTIONNAIRE (CHP 462A)

STATE OF CALIFORNIA
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

SENIOR VOLUNTEER PROGRAM MEDICAL QUESTIONNAIRE

CHP 462A (New 8-00) OPI 004

LAST NAME	FIRST NAME	MIDDLE INITIAL	TODAY'S DATE

SEX	DATE OF BIRTH *(MONTH/DAY/YEAR)*
☐ Male ☐ Female	

HEALTH INSURANCE COMPANY	POLICY NUMBER

PERSONAL PHYSICIAN	PHONE NUMBER

DOCTOR'S ADDRESS	CITY	STATE	ZIP CODE

Date of your most recent complete physical examination (Month/Year): _____

Are you aware of any current health problems? ☐ Yes ☐ No

Are you currently under a doctor's care or taking any medications? ☐ Yes ☐ No
(If yes, please explain)

_____

_____

_____

Have you ever been, or are you now, subject to any of the following: (Please explain any checked box)

☐ Allergies to medicines, foods, plants, animals, or insects
☐ Asthma
☐ Any conditions that may require special care, medicines, or diet
☐ Bleeding Disorders
☐ Contact Lenses
☐ Convulsions
☐ Dentures
☐ Diabetes
☐ Fainting
☐ Heart Disease
☐ Restrictions on driving
☐ Restrictions on physical activity

_____

_____

_____

I certify that I have provided true and complete information concerning my health. I understand that any misrepresentation or material omission may be cause for dismissal. I give my permission for the Senior Volunteer Coordinator Program to contact my physician to discuss volunteer-related health issues.

SIGNATURE	DATE

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