Safety Management Survey

*The information provided will only be used for safety management in relevant classes.

| Today's date: | Y | М | D |) | Course title: | | | | | |
|---------------|--------|------|-----|--------------------|---------------|---------|--|--|--|--|
| Name: | | | | Department (Year): | | | | | | |
| Age: | Gender | :M I | ſŦ. | Phon | e number: | Email*: | | | | |

X: Please provide an e-mail address that can receive attachment files, such as study guidance materials.

<Emergency Contact>

| Name: | Relationship to the student: | Phone number: |
|-------|------------------------------|---------------|
|-------|------------------------------|---------------|

 1 . Do you have any allergies you need to be mindful of during
 Yes
 No

 your stay?
 No
 No

• If you answered "yes," please fill in the information below.

| Drugs or chemicals: | | | | | |
|----------------------------|--|--|--|--|--|
| Hay fever, plants, etc.: | | | | | |
| Bee stings, other insects: | | | | | |
| Metal, sunlight, other: | | | | | |
| Foods ^{**} : | | | | | |

<u>XIf you have any food allergies, please fill out the Food Allergy Questionnaire on a separate sheet.</u>

| 2. | Have you ever experienced anaphylactic shock? | Yes | No | | | | | |
|----|---|--------|----|--|--|--|--|--|
| | • If you answered "yes," please answer the following questio | ns. | | | | | | |
| | • What caused the anaphylactic shock? | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | \cdot If you carry an EpiPen, please describe where it is located in de | etail. | | | | | | |
| | ((Ex: It is in the red pouch I carry.) | | | | | | | |
| | | | | | | | | |

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Please consult a doctor if you have allergies that require medication or may potentially go into anaphylactic shock

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| 3. Are you currently undergoing treatment you need to be aware of during your studies? | Yes | No |
|--|-----|----|
| uuning your studies: | | |

• If you replied "yes," please circle the relevant items.

| Seizures | • | Asthma | • | Epilepsy | • | Hives | • | Kidney disease | • | Diabetes | • | Heart disease | • |
|------------|-----|---------|--------|--------------|-----|-------|-----|-------------------|-----|----------|---|---------------|---|
| Appendicit | tis | • Ortho | statio | e dysregulat | ion | • E | xer | cise-induced Anap | hyl | laxis • | | | |
| Other (| | | | | | | | | | | | |) |

4. Including your response to Q3, please write in the blank below if you are currently seeing a doctor, being treated, or on medication for any issues. In an emergency, please describe in as much detail as possible what kind of first aid should be administered until you can get to a hospital.

5. If you have ever taken or have plans to take any lectures offered by the University of Tsukuba Mountain Science Center Sugadaira Research Station, please fill in the blanks below.

| Lectures | |
|----------------|--|
| taken thus far | |
| Lectures you | |
| plan to take | |

6. If you have any other concerns or information you would like to communicate to the faculty in charge, please write them in the space below.