

<b>FOR OFFICE USE ONLY – DO NOT FILL IN</b>		<input type="checkbox"/>	PORTACOUNT
<input type="checkbox"/>	3M 8210/1860	<input type="checkbox"/>	KC PFR95 – 62126 (Reg)
<input type="checkbox"/>	3M 8110S/1860S	<input type="checkbox"/>	KC PFR95 – 62355 (Sml)
<input type="checkbox"/>	3M 9210/1870	<input type="checkbox"/>	OTHER _____

## **N95 RESPIRATOR HEALTH QUESTIONNAIRE**

*THIS FORM IS CONFIDENTIAL ONCE COMPLETED*

Mask Fitting will be completed in room 258B; Health Studies Lab

<b>Last Name:</b>	<b>First name:</b>
<b>Student #:</b>	<b>Telephone #:</b>
<b>Program NAME:</b>	<b>Current Semester: (please circle)</b> 1 2 3 4 5 6 7 8

### **PLEASE READ CAREFULLY AND COMPLETE BOTH PAGES**

### **ANY OMISSIONS OR NON-COMPLIANCE WILL RESULT IN YOU HAVING TO REBOOK AN APPOINTMENT AT YOUR EXPENSE**

- Some symptoms/conditions can affect your ability to be safely tested and use a respirator mask
- If you select 'YES' to ANY questions on page 2, please see your family doctor at least **ONE WEEK PRIOR TO YOUR APPOINTMENT** to review and discuss any concerns
  - If you select 'YES' to **PREGNANCY**, or if requested by the nurse for any other conditions, a **doctor MUST complete** the section on page 2
- Students **MUST HAVE NON-EXPIRED** puffers or necessary/emergency medication with them prior to testing
- Individuals **MUST** be **CLEAN SHAVEN** prior to testing
  - Regarding religious/cultural reasons for facial hair; please discuss it with technician at least **24 hours before** your scheduled appointment
- Do not eat (including gum) or drink (except water) or smoke 30 minutes prior to your appointment
- Please arrive to your appointment **15 minutes** prior to the start; please accommodate for travel conditions / time
  - **Late arrivals will not be admitted, and require a rebooking of the appointment**
- Previous mask fitting cards **may** be accepted; please see Michelle Wray for approval (**ext 8122**)
- Failure to meet any of the above will result in a **refusal** to be tested and require rebooking of an appointment
- Rebooking will be completed at **Room 352** at a cost of **\$30.00 (cash)**

**By signing the bottom of page 2, the individual agrees:**

- |  |
|--|
| <ul style="list-style-type: none"> <li>○ To fully understanding and to compliance of the rules and procedure of the Mask Fit Testing process</li> <li>○ That all information provided is correct and not falsified</li> <li>○ Any issues or concerns have been or will be discussed with the technician PRIOR to testing</li> <li>○ Any non-compliance will result in forfeit of the appointment; rescheduling to occur at your expense</li> </ul> |
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**If you select 'yes' to ANY questions below, please see your family doctor ONE WEEK PRIOR TO YOUR APPOINTMENT to review and discuss any concerns**

**Do you or have you recently (within 1 yr) had any of the following respiratory conditions?**

- COPD/Asthma /Bronchitis/Emphysema \_\_\_\_\_ Yes No
- Persistent cough \_\_\_\_\_ Yes No
- Other causes of shortness of breath \_\_\_\_\_ Yes No  
If yes; please specify known cause(s) \_\_\_\_\_
  
- Any food or drug or material (example: Latex) allergies Yes No  
If yes; please specify known cause(s) \_\_\_\_\_

**Do you or have you recently (within 1 yr) had any of the following conditions?**

- Feelings of Claustrophobia (fear of close, tight spaces) Yes No
- Epilepsy / Seizure Disorder \_\_\_\_\_ Yes No  
If yes; please specify known cause(s) \_\_\_\_\_
  
- History of fainting / syncope \_\_\_\_\_ Yes No  
If yes; please specify known cause(s) \_\_\_\_\_
  
- Heart condition \_\_\_\_\_ Yes No  
If yes; please specify \_\_\_\_\_
  
- High blood pressure \_\_\_\_\_ Yes No

**Are you pregnant? (If YES, you MUST receive clearance from a physician)** Yes No  
If yes; please circle your trimester → 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>

➤ Current pregnancy-related complications \_\_\_\_\_ Yes No  
If yes; please specify \_\_\_\_\_

**TO BE COMPLETED BY A PHYSICIAN -- For PREGNANCY or AT THE REQUEST OF THE NURSE**

Assessments: \_\_\_\_\_  
Pertinent Medical History: \_\_\_\_\_  
Precautions/Additional Notes: \_\_\_\_\_

SUITABLE FOR MASKFITTING:  YES  NO      PHYSICIAN'S NAME: \_\_\_\_\_  
DATE: \_\_\_\_\_  
PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_      PHYSICIAN'S SIGNATURE: \_\_\_\_\_

\_\_\_\_\_  
STUDENT SIGNATURE

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DATE    YYYY    MM    DD