Health and Medical Form

Student: _____; D.O.B.: _____; Age: _____; SSN:_____
(Last) (First) (MI) (full or last four digits)

IN CASE OF EMERGENCY, NOTIFY:

Name: _____; SSN: _____; Relationship: _____
(Printed) **Parent or Guardian** (full or last four digits)
Address: _____; Phone (home): _____(work)_____
(Street) (City) (St) (Zip)
Health Insurance Company: _____; Policy No. _____
Family Physician: _____; Phone: _____
(Note: Student must be covered by medical insurance as a precondition to attending the Leadership Conference.)

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(This form must be signed by parent, or guardian, if student named above is under 18 years of age.)

I (we) the undersigned parent(s) {or guardian(s)} of the named minor, do hereby authorize the Military Order Of the World Wars Youth Leadership Conference's Medical Officer, or his nominee, as agent for the undersigned to consent to any X-Ray, Examination, Anesthesia, Medical or Surgical Diagnosis or treatment and hospital care which is deemed advisable by, or which is to be rendered under the general or special supervision of any Physician or Surgeon licensed to practice in the state of the Youth Leadership Conference.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent to care, which the aforementioned Physician, in the exercise of his best judgment may deem advisable. This authorization will be effective from the first through the last day of the Conference, unless sooner revoked in writing and delivered to said agent.

_____ _____ _____
(Date) **(Signature of Parent or Guardian)** **(Phone No.)**

Medical History

Date of last complete physical examination (month and Year): _____. Has it ever been necessary to restrict the student's physical activities for medical reasons? Yes □ No □. If **YES**, explain in full:
_____.
Are you aware of any current health problems? Yes □ No □. If **YES**, explain :
_____.
Are you now under medical care or regularly taking medications? Yes □ No □. If **YES**, explain:
_____.
Has there been any significant surgery, injury, illness or change in your health status since your last physical examination? Yes □ No □. If **YES**, explain: _____.

Date of immunizations: TETANUS _____; DIPHTHERIA _____; POLIO _____
MUMPS _____; MEASELS _____; RUBELLA _____; PERTUSSIS _____.

EMERGENCY MEDICAL INFORMATION

If you are subject to any of the following, check the box and explain in detail:
□ Allergy to any plant, food, or animal: _____.
□ Allergy to any drug or insect toxin: _____.
□ Any condition requiring regular medical, dietary or special care: _____
_____.
□ Asthma □ Convulsions □ Heart Trouble □ Diabetes □ Bleeding Disorders □ Others, explain _____
_____.

_____ _____
Signature of parent or guardian Date

Email Parent: _____ Email Student: _____

(Please use reverse and/or additional sheets to complete explanation for any of the above items)