Leadership Institute Medical Emergency Consent Form

Student's Name:				
Home Address:				
Birth date:				
Social Security Number:	Sex: F	M	_ Age:	
Home Phone #:				
Mother / Father / Guardian (Please circle) Name	:			
Business Address:	Business F	Business Phone #:		
Name of Family Physician:	Phor	Phone #:		
Name of Medical Insurance Company:				
Policy or Group Number:	Employee	Employee Number:		
Please list any medical conditions the Leadershi (medication, physical needs, etc.):	·			
If parents / guardians are not available in an				
Name:	Relationship:			
Address:	Phone:			
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Medical Emergency Consent

In case of medical emergency, we/I understand that every reasonable effort will be made to contact me. In the event that we/I cannot be reached, this consent shall allow the Leadership Institute Staff to obtain whatever emergency treatment and/or care is deemed necessary for the health and well-being of the student during his/her participation. In case of medical emergency, we/I consent to any anesthetic, medical, or surgical diagnostic testing and/or treatment to be rendered to the student under the supervision and on the advice of a licensed physician when the need for such treatment is immediate and when your efforts to contact me are unsuccessful.

Signature of parent/guardian

Date

Print Name

Health History

Allergies: (Please check all that apply.)

Animals	Hay Fever	Plants (Ivy, Oak, etc.)
Asthma	Insect Stings	Pollen
Food	Medicine/Drugs	Other

Please explain any items that are checked.

Health Conditions: (Please check all that apply.)

Bed Wetting	Ear Infections	Menstrual Cramps
Behavior Problems	Emotional Disturbances	Nosebleeds
Bleeding/Clotting	Fainting	Prescription Drugs
Constipation	Hearing Impairment	Seizures
Convulsions	Heart Defect/Disease	Sleep Disturbances
Diabetes	Motion Sickness	Wear Glasses/Contacts

Please explain any items that are checked. Indicate any information that would be useful to the Leadership Institute staff in relation to any of these conditions or any other conditions:

Recent operations or serious injuries and dates: _____

Immunization	s: DTP (Diptheria/Tetanus/Whooping Cough) MMR (Measles/Mumps/Rubella) Polio
Check one:	 Current as required by state law for school attendance. Not current, but in the process of getting immunizations. Not current, because of health, religious or personal convictions.

Medical Release

This health history is correct as far as I know and the student herein described is in sound physical health and has my permission to engage in all planned physical activities. Please list any medical or activity restrictions, conditions, allergies or medications that the Leadership Institute Staff should be aware of:

Signature of parent/guardian

Date

Print Name