MEDICAL FORM

To be completed by every participant in any activity.

Please note that the activity leadership must have the ORIGINAL form. (Some hospitals will not accept copies).

Activities such as field days, day hikes and conferences and academies where medical staff is available a medical history is required but a physicians evaluation is not required.

Activity such as resident camping, extended outings, hiking & boating in remote areas where medical staff is not readily available requires a physicians evaluation (signature required on 2nd page of this form)

PARTICIPANT INFORMATION: (Required) ☐☐☐☐☐ Group/Post No. ☐☐☐ Local LFL Office No. ☐☐☐☐☐☐☐☐☐☐☐ LFL Headquarters City

Last Name ____________ First Name ____________ MI ____ Phone ( ) ____________

Address ____________ City ____________ State ____ Zip ____

Registered as (Required): Youth_____ / Adult_____ Gender: Male_____ / Female_____ Age_____ / Birth Date___/___/______

Name of adult leader participating in the activity who agrees to be responsible for this participant ____________

Overnight Activities: All leaders must be registered as an adult with Learning for Life and provide male leaders for male youth participants and female leaders for female youth participants.)

MEDICAL INFORMATION

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, plants, medicines, insect bites Yes ☐ No ☐ Explain: ____________

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Attention Deficit/Hyperactivity Disorder (ADHD)	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/Leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

Explain: ____________

List any medications to be taken during the activity. ____________

List ALL medications taken in the 30 days prior to arrival. ____________

List any physical or behavioral conditons that may affect or limit full participation. ____________

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc: ____________

IMMUNIZATIONS (Date of last inoculation):

Chicken Pox ______	Lyme Disease (not required) ______	Pertussis ______	Rubella ______
Diphtheria ______	Measles ______	Polio ______	TetanusToxoid ______
Hepatitis B ______	Mumps ______		

PARENT/GUARDIAN INFORMATION:

Name of parent or guardian ____________ Telephone ____________

Home address ____________

City ____________ State ______ Zip ______

Name of personal physician ____________ Telephone ____________

Personal health/accident insurance carrier ____________ Policy no. ____________

In case of emergency during the activity, notify:

Name: ______________________________

Relationship: ______________ E-Mail Address ______________

Street address ______________ City ______________ State____ Zip________

(   ) ______________ (   ) ______________ (   ) ______________
Area Code Day Phone Area Code Evening Phone Area Code Pager/Mobile

If person named above is not available in the event of an emergency, notify:

Name	Relationship	Telephone	E-Mail Address

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Signature of parent/guardian ______________________________ **Date** ______________

STATEMENT OF UNDERSTANDING and SIGNATURES (To be completed by all adult and youth participants)

I understand the importance of providing accurate medical information, and I certify to the accuracy of the foregoing information and that I am in good health and know of no personal physical limitations that would prevent my full participation in the conference (unless noted).

I understand that this application includes my request for other personal accident insurance to be purchased on my behalf, and the cost of this insurance is included in the registration fee.

As an Adult Leader I will follow activity requirements for participation or as a youth participant, I will be responsible to my Adult Leader.

In the event of illness or injury occurring to me or to my son/daughter (if applicant is younger than 18) during attendance at the conference, I do hereby consent to whatever X-ray examination, anesthesia, medical or surgical diagnostic procedure, or treatment is considered reasonable and necessary in the best judgment of the attending licensed physician and performed by or under the supervision of a member of the medical staff of the hospital furnishing medical services.

I understand that in the event of a serious illness or injury, reasonable efforts to notify those listed in case of emergency will be attempted.

Does your group/post currently have accident and sickness insurance on adults and your participants? Yes____ No____

Insurer: ______________________________

Policy expiration date ______________ ***Policy No.*** ______________

Signature of participant ______________________________ Date______________

Signature of parent or guardian ______________________________ *(Required if participant is younger than 18)*

Signature of Adult Leader* ______________________________ Group/Post No. ________ LFL No.________

* **Overnight Activities:** All leaders must be registered as an adult with Learning for Life and provide male leaders for male youth participants and female leaders for female youth participants.

REQUIRED FOR PARTICIPATION IN A CAMPING EXPERIENCE: COMPLETE THE PHYSICIAN'S OR LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION.

PHYSICIAN'S OR LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION

Approved for participation in: ☐ Hiking and camping ☐ Competitive sports ☐ Water activities ☐ All activities

Specify exceptions ______________________________

Recommendations (explain any restrictions OR limitations): ______________________________

____

Signed by Physician or Licensed health-care practitioner* ______________________________ Date__________

*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for Learning for Life purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.