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 conditions 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

_____ _____ _____ _____

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.