MEDICAL AUTHORIZATION

DO NOT STAPLE INSURANCE CARDS OR FORMS TOGETHER. PRINT NEATLY AND USE A BLACK PEN

Name _____ Date of Birth___ /___/_____ Gender___ (M/F) E-Mail _____

Address_____ City_____ State_____ Zip_____

Guardian 1_____ Guardian 2 _____ Custodial Guardian _____

Home Phone_____ Home Phone _____

Work Phone _____ Work Phone _____

Cell Phone_____ Cell Phone _____

List the following information for the person who carries medical insurance on the registrant:

Full Name _____ Soc. Sec. No. _____

Address_____ City_____ State____ Zip Code_____

Insurance Co._____ ID, Group & Plan Nos. _____

Please provide a copy of the insurance card

MEDICAL HISTORY OF LAB PARTICIPANT

CURRENTLY HAS OR HAS EVER HAD	**NO**	**YES**	
FOOD, MEDICATION, OR ENVIRONMENTAL ALLERGIES	_____	_____	SPECIFY_____
ASTHMA (OR OTHER RESPIRATORY ILLNESS)	_____	_____	SPECIFY_____
DIABETES	_____	_____	SPECIFY_____
SEIZURE / EPILEPSY	_____	_____	SPECIFY_____
HEART OR BLOOD PRESSURE CONDITION	_____	_____	SPECIFY_____
MENTAL HEALTH CONDITION	_____	_____	SPECIFY_____
ORTHOPEDIC ISSUES REQUIRING MEDICAL ATTENTION	_____	_____	SPECIFY_____
ANY CONDITION LIMITING STRENUOUS ACTIVITY	_____	_____	SPECIFY_____
SERIOUS ILLNESS / INJURY REQUIRING HOSPITALIZATION	_____	_____	SPECIFY_____

ANY OTHER HEALTH RELATED ISSUE(S)

SPECIFY_____

DAILY MEDICATIONS (NAME, DOSAGE, TIMES, CONDITION MEDICATION TREATS)

SPECIFY_____

AS NEEDED MEDICATIONS (NAME, DOSAGE, FREQUENCY, CONDITION MEDICATION TREATS)

SPECIFY_____

Is this person normally aware of his/her own health care needs? Yes_____ No _____

Emergency Contact. Limit Two:

Name & Relationship

Phone #_____ Phone #

Name & Relationship

Phone #_____ Phone #_____

My son/daughter has permission to engage in all Leadership Lab activities. In the event of an urgent medical matter, if I cannot be reached, I hereby give permission to the Leadership Lab official and/or his/her designee to secure and authorize in my absence any and all medical treatment he/she deems necessary, including but not limited to Emergency Department treatment, laboratory tests, radiological tests/procedures, intravenous fluids, medications, physician services, and/or surgical procedures, for my child named above. In addition, I give my permission for the Leadership Lab official and/or his/her designee to exchange information regarding my child's medical history and current medical/health status with the physician and medical facility staff.

X_____ **X**_____ Date: ___/___/2018

Parent/guardian if participant under 18 years **Participant under 18 years**

For the Labber that is 18 yrs of age or older. I accept responsibility for my physical well being while attending Leadership Lab activities. In the event of an urgent medical matter, if I cannot consent for myself, I hereby give permission to the Leadership Lab official and/or his/her designee to secure and authorize any and all medical treatment he/she deems necessary, including but not limited to Emergency Department treatment, laboratory tests, radiological tests/procedures, intravenous fluids, medications, physician services, and/or surgical procedures, for me. I give my permission for the Leadership Lab official and/or his/her designee to exchange information regarding my medical history, current medical/health status, test results and treatment with the physician and/or medical facility staff. In addition, I give my permission for the Leadership Lab official, his/her designee, the physician and/or the medical facility staff to exchange information with my emergency contact(s) listed above regarding my test results, treatment and health status. I also give permission to share any medical information with the emergency contacts listed above.

X _____ Date: ___/___/ 2018

Signature of Participant (18 years of age or older)