

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: ___/___/2019

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: ___/___/2019

Signature of Participant (18 years of age or older)