

Participants Health and Medical History:

1. Does the participant have any known allergies? (food, medication, plants, insects, etc.)
Yes _____ No _____ Please explain _____

2. Has the participant ever experienced (or had special needs in) any of the following?
_____ Asthma _____ Bleeding Disorders _____ Behavior
_____ Seizure/Convulsions _____ Wears Contacts _____ Diabetes
_____ Eating Disorders _____ Fainting Spells
_____ Attention Disorders (ADHD) _____ Other _____
3. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication?
Please explain _____

4. Has the participant undergone surgery, or experienced any injury, illness allergy or change in health status anytime during the last year? Is there any reason to restrict program participation? Yes _____ No _____ Please explain _____

5. Does the Participant require a special diet? (vegetarian, dietary restrictions allergy)
Yes _____ No _____ Please explain _____
6. Is there any additional information essential for the Staff to know in order to provide appropriate supervision, support and accommodations for the participant?
Yes _____ No _____ Please explain _____

MEDICAL APPROVAL/EMERGENCY AUTHORIZATION/AUTHENTICATION

The information on this form is true and complete to the best of my knowledge. I give permission for the participant named on this form to take part in the American Patriot Conference. He/She has my permission to participate in all scheduled activities which may include physical activity (athletics), bus tours and related activities under the supervision of the adult counselors.

I give permission to the program staff to order x-rays, routine tests and treatment for my child (or myself if over 18 years of age) as medically necessary. I give permission for the program staff to give the program participant OVER-THE-COUNTER medications he/she requests for discomforts (such as headaches or upset stomach). If I cannot be reached in an emergency, I give my permission to the program staff to secure proper treatment for, hospitalization and to order injection and/or anesthesia and/or surgery for the participant named on this form in conjunction with qualified medical personnel. This form may be photo copied for use outside the event location.

SIGNED _____ DATE _____
(Parent/Legal Guardian or Participant over age 18)

SIGNED _____ DATE _____
(Participant under age 18)