PARTICIPANT HEALTH AND MEDICAL HISTORY

1. Does the participant have any known allergies? (food, medicine, plants, animals, insects ,other)
YES ____ NO ____ if YES , please explain: ______________________________

2. Has the participant ever experienced (or had special needs in) any of the following?
[Check (✓) all that apply]

____ Asthma
____Diabetes
____Seizure/Convulsions
____Fainting Spells
____Bleeding disorders
____Bed Wetting
____Wears Contacts
____Other ______________________________
____Attention disorders (ADHD)
____Eating Disorders
____Behavior

3. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication?
YES ____ NO ____ if YES , please explain: ______________________________

4. Has the participant undergone surgery, or experienced any injury , illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted?
YES ____ NO ____ if YES , please explain: ______________________________

5. Does the participant require a special diet (including vegetarian, dietary restrictions or allergies)?
YES ____ NO ____ if YES , please explain: ______________________________

6. Is there additional information essential staff should know in order to provide appropriate supervision, support, and accommodations for the participant?
YES ____ NO ____ if YES , please explain: ______________________________

MEDICAL APPROVAL / EMERGENCY AUTHORIZATION /AUTHENTICATION

The information on this form is true 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, basketball, volleyball, kayaking, canoeing, firearm safety, bus tours and related activities under the supervision of adult counselors.

I give permission to the program staff to order X-rays, routine tests and treatment for my child (or for myself if I am a participant over 18 years old) 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 headache or upset stomach. If I cannot be reached in an emergency, I give permission to the program staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the participant named on this form. This form may be photo copied for use outside of the event location.

SIGNED: **X** ______________________________ DATE: ______________
(Parent / Legal Guardian or participant over 18 years old)

I understand and agree to abide by the restrictions placed on my activities according to this form.

SIGNED: **X** ______________________________ DATE: ______________
(Participant under 18 years old)