STAFF MEDICAL HISTORY

Staff Members Under 18

If you are to attend and participate in the IEFLP Leadership Conference, you and your parent (or guardian) must complete this medical history form. **You cannot attend the Conference if this information is not returned to us.** Kindly supply all requested information.
Please attach a recent photograph at left. PLEASE TYPE OR PRINT.

Last Name	First Name	MI	Sex	Birthdate	Birthplace

Address	City	State	ZIP	Home Phone
				( )

Full Name of person to notify in case of emergency:	Relationship

Address	City	State	ZIP	Work Phone
				( )

Family Doctor	Doctor's Address	City	State	ZIP	Doctor's Phone
					( )

Medical Insurance Information

Policy Holder	Health Plan/Insurance Company

Policy Number	Expiration Date

1. If you do not have medical insurance, how do you get medical services?

2. Is your child experiencing any of the following medical problems:

Asthma	**Yes** ☐	**No** ☐	Stomach Problems	**Yes** ☐	**No** ☐
Blood Disorders (Anemia)	**Yes** ☐	**No** ☐	Migraine Headaches	**Yes** ☐	**No** ☐
Menstrual Disorders	**Yes** ☐	**No** ☐	Seizure Disorder	**Yes** ☐	**No** ☐

3. Please list any other ongoing medical problems:

4. Does your child have any allergies?
(Medications, foods, bee stings, plants, Insect bites, etc.) **Yes** ☐ **No** ☐

To what? ____

Describe her/his reaction. (In your description indicate if it is mild, moderate, or severe.)

____

How do you treat it?____

Does your child carry an EpiPen®? **Yes** ☐ **No** ☐

Inland Empire Future Leaders Program

STAFF MEDICAL HISTORY

Staff Members Under 18

(continued)

5. Is your child taking any medications prescribed by a doctor? Yes ☐ No ☐

Is he/she taking any other medications (including over-the-counter medications)? Yes ☐ No ☐

If your child takes any medications, please make a list of those medications (prescribed or over-the-counter) that she/he will be taking during the conference. Please attach a list to this form or list them on the back of this form. If your child has an inhaler and a spare, be sure she/he to brings them.

6. When was your child's last tetanus shot? Month ____________ Year _____________

Please attach a copy of his/her vaccination record. If record is not submitted, your child cannot be accepted.

Tetanus shot is good for ten years. If not current, it **MUST** be updated. Contact us if you need a referral to a free clinic.

7. Do your child have limitations to physical exercise? Please explain.

8. Please describe any special dietary needs.

9. Eating disorders can be detrimental to the health of a participant, particularly in the altitude and warm climate at the Conference. Some disorders such as anorexia cannot be accommodated at the Conference. For their personal safety, participants discovered to have eating disorders will be sent home.

Please initial here: __________

Participant's Signature	Date	Parent's/Guardian's Signature	Date
Print name as signed above		Print name as signed above	