MEDICAL AUTHORIZATION

NAME ___________________________________ BIRTH DATE ______________________

HOME ADDRESS ____

____ PHONE __________________________
(City) (State) (Zip) (area code)

It is important to have certain medical information so that any emergency may be taken care of as adequately and quickly as possible.

Please complete the blanks below and submit other information you feel is applicable:

1. Date of last physical examination ____
2. Allergies (medication, insect bites, etc.) ____________________________________
3. Date of last tetanus immunization ____
4. Do you have a history of: heart condition? _________ Diabetes? _________
   Asthma ______________ rheumatic fever? __________
5. Do you have any physical restrictions? ____________________________________
   ____
6. Other conditions leaders should be aware of ___________________________________
   ____

NAME OF HOME-TOWN PHYSICIAN ____

PHONE NUMBER OF FAMILY PHYSICIAN ___________________________________

MEDICAL INSURANCE COMPANY AND POLICY NUMBER ____________________

I understand that should a health problem arise, I will be notified, but if I cannot be reached by telephone, such medical treatment, including surgery, as deemed necessary by competent medical personnel could be rendered.

EVENT ____

DATES of EVENT ____

SIGNATURE(S) ____
(Parent or guardian)