MEDICAL FORM

District_____

Medical Form must be completed by all students attending
New York State Family, Career and Community Leaders of America Events

NAME _____ Date of Birth _____

School _____ Advisor _____

Parent/guardian _____

Address _____

Phone: Home _____ Business _____

Contact *(If parent not available)* _____ Phone _____

Insurance Co. _____ Policy number _____

Duplicate below or attach copy of both sides of card

Physician _____ Phone _____

Please completely describe any medical condition which may recur or be a factor in medical treatment.

Allergy _____ Diabetes _____

Asthma _____ Blackouts _____

Medicine Reactions _____ Physical Handicap _____

Heart/lung problem _____ Convulsions _____

Other (be specific) _____

Medication(s): _____

(prescription copy if possible)

In the event of illness or accident, I hereby give permission for _____ 's emergency medical treatment:

(name)

PARENT/GUARDIAN'S SIGNATURE _____ Date _____