

Conclave 2009 Delegate Medical Form

To be filled out by parent/guardian or adult participant. Please print in ink.			
Delegate Information			
Name:		Email:	
Address:			
City:	State:	Zip Code:	
Phone: ()		Date of Birth:	
Circle One:	Ordeal	Brotherhood	Vigil
Primary Emergency Contact			
Name:		Relationship:	
Day Phone: ()		Night Phone: ()	
Secondary Emergency Contact			
Name:		Relationship:	
Day Phone: ()		Night Phone: ()	
Medical Information			
Do you: <input type="checkbox"/> have any medical restrictions? <input type="checkbox"/> currently take any medication? <input type="checkbox"/> have any dietary restrictions?		Explain:	
Health Insurance Company:		Policy #:	
Have or subject to: <input type="checkbox"/> Convulsions <input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart trouble <input type="checkbox"/> Allergy to medication, food plant, animal, or insect <input type="checkbox"/> Any condition requires special care, medication, or diet <input type="checkbox"/> NONE OF THE ABOVE APPLY		Explain:	
Have difficulty with (check if yes): <input type="checkbox"/> Eyes, ears, nose, throat <input type="checkbox"/> Digestion <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Lungs <input type="checkbox"/> Sleepwalking		Explain:	
<input type="checkbox"/> Any condition now requiring regular medication?		Name of medication:	
Last Tetanus toxoid date:			
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. In the event that I cannot be reached in an emergency, I hereby, give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection.			
Participant		Parent or guardian	
Signature:		Signature (if participant under 18 years):	
x _____ Date: _____		x _____ Date: _____	