

# MEDICAL AUTHORIZATION

DO NOT STAPLE INSURANCE CARDS OR FORMS TOGETHER. PRINT NEATLY AND USE A BLACK PEN

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Gender \_\_\_ E-Mail \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mother \_\_\_\_\_ Father \_\_\_\_\_ Custodial Parent \_\_\_\_\_  
Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**List the following information for the person who carries medical insurance on the registrant:**

Full Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ ID, Group & Plan Nos. \_\_\_\_\_

**Please provide a copy of the insurance card**

## MEDICAL HISTORY OF LAB PARTICIPANT

**CURRENTLY HAS OR HAS EVER HAD**

**NO YES**

FOOD, MEDICATION, OR ENVIRONMENTAL ALLERGIES \_\_\_\_\_ SPECIFY \_\_\_\_\_  
ASTHMA (OR OTHER RESPIRATORY ILLNESS) \_\_\_\_\_ SPECIFY \_\_\_\_\_  
DIABETES \_\_\_\_\_ SPECIFY \_\_\_\_\_  
SEIZURE / EPILEPSY \_\_\_\_\_ SPECIFY \_\_\_\_\_  
HEART OR BLOOD PRESSURE CONDITION \_\_\_\_\_ SPECIFY \_\_\_\_\_  
MENTAL HEALTH CONDITION \_\_\_\_\_ SPECIFY \_\_\_\_\_  
ORTHOPEDIC ISSUES REQUIRING MEDICAL ATTENTION \_\_\_\_\_ SPECIFY \_\_\_\_\_  
ANY CONDITION LIMITING STRENUOUS ACTIVITY \_\_\_\_\_ SPECIFY \_\_\_\_\_  
SERIOUS ILLNESS / INJURY REQUIRING HOSPITALIZATION \_\_\_\_\_ SPECIFY \_\_\_\_\_

**ANY OTHER HEALTH RELATED ISSUE(S)**

SPECIFY \_\_\_\_\_

**DAILY MEDICATIONS (NAME, DOSAGE, TIMES, CONDITION MEDICATION TREATS)**

SPECIFY \_\_\_\_\_

**AS NEEDED MEDICATIONS (NAME, DOSAGE, FREQUENCY, CONDITION MEDICATION TREATS)**

SPECIFY \_\_\_\_\_

Is this person normally aware of his/her own health care needs? Yes \_\_\_\_\_ No \_\_\_\_\_

**Emergency Contact. Limit Two:**

Name & Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Name & Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

My son/daughter has permission to engage in all Leadership Lab activities. In the event of an urgent medical matter, if I cannot be reached, I hereby give permission to the Leadership Lab official and/or his/her designee to secure and authorize in my absence any and all medical treatment he/she deems necessary, including but not limited to Emergency Department treatment, laboratory tests, radiological tests/procedures, intravenous fluids, medications, physician services, and/or surgical procedures, for my child named above. In addition, I give my permission for the Leadership Lab official and/or his/her designee to exchange information regarding my child's medical history and current medical/health status with the physician and medical facility staff.

X \_\_\_\_\_ X \_\_\_\_\_ Date: \_\_\_/\_\_\_/2010

**Parent/guardian if participant under 18 years**

**Participant under 18 years**

**For the Labber that is 18 yrs of age or older.** I accept responsibility for my physical well being while attending Leadership Lab activities. In the event of an urgent medical matter, if I cannot consent for myself, I hereby give permission to the Leadership Lab official and/or his/her designee to secure and authorize any and all medical treatment he/she deems necessary, including but not limited to Emergency Department treatment, laboratory tests, radiological tests/procedures, intravenous fluids, medications, physician services, and/or surgical procedures, for me. I give my permission for the Leadership Lab official and/or his/her designee to exchange information regarding my medical history, current medical/health status, test results and treatment with the physician and/or medical facility staff. In addition, I give my permission for the Leadership Lab official, his/her designee, the physician and/or the medical facility staff to exchange information with my emergency contact(s) listed above regarding my test results, treatment and health status.

X \_\_\_\_\_ Date: \_\_\_/\_\_\_/2010

**Signature of Participant (over 18 years of age)**