

The Military Order of the World Wars Health and Medical Form

Student: _____ ; D.O.B.: _____ ; Age: _____ ; SSN: _____
(Last) (First) (MI)

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ ; SSN: _____ ; Relationship: _____

Address: _____ ; Phone (home): _____ (work) _____

Health Insurance Company: _____ ; Policy No. _____

Family Physician: _____ ; Phone: _____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(This form must be signed by parent, or guardian, if student named above is under 18 years of age.)

I (we) the undersigned parent(s) {or guardian(s)} of the named minor, do hereby authorize the Military Order Of the World Wars Youth Leadership Conference's Medical Officer, or his nominee, as agent for the undersigned to consent to any X-Ray, Examination, Anesthesia, Medical or Surgical Diagnosis or treatment and hospital care which is deemed advisable by, or which is to be rendered under the general or special supervision of any Physician or Surgeon licensed to practice in this state.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent to care, which the aforementioned Physician, in the exercise of his best judgement may deem advisable. This authorization will be effective from the first through the last day of the Conference, unless sooner revoked in writing and delivered to said agent.

(Date)

(Signature of Parent or Guardian)

(Phone No.)

Medical History

Date of last complete physical examination (month and Year): _____. Has it ever been necessary to restrict your physical activities for medical reasons? Yes No . If YES, explain in full:

Are you aware of any current health problems? Yes No . If YES, explain :

Are you now under medical care or regularly taking medications? Yes No . If YES, explain:

Has there been any significant surgery, injury, illness or change in health status since your last physical examination? Yes No . If YES, explain: _____.

Date of immunizations: TETANUS _____; DIPHTHERIA _____; POLIO _____;
MUMPS _____; MEASELS _____; RUBELLA _____; PERTUSSIS _____.

EMERGENCY MEDICAL INFORMATION

If subject to any of the following, check the box and explain in detail:

Allergy to any plant, food, or animal: _____.

Allergy to any drug or insect toxin: _____.

Any condition requiring regular medication or diet or special care: _____.

Asthma Convulsions Heart Trouble Diabetes Bleeding Disorders Others, explain _____

Student Signature

Date

(Please use reverse or additional sheets to complete explanation of any of the above items)