



# Young Leaders Today Conference 4

February 24-26, 2012

## Health Questionnaire & Medical Release Form (To be filled out by parent/guardian and returned)

Name: \_\_\_\_\_

Street  
Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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Parent/Guardian: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family medical/hospital insurance carrier: \_\_\_\_\_

Policy/Group No.: \_\_\_\_\_

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**In case of Emergency:**

Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

1. Are you currently under medical care?

- No
- Yes (please explain) \_\_\_\_\_

\_\_\_\_\_

2. Please list any medications and dosages you will be bringing.

\_\_\_\_\_

\_\_\_\_\_

3. Are you allergic to any medications?

- No
- Yes (please list) \_\_\_\_\_

\_\_\_\_\_

4. Please check any illnesses/injuries that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Ear infection                 | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Heart Defect/Disease          | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Bleeding/Clotting Disorders   | <input type="checkbox"/> Muscle/Bone Disorders |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Other (Please specify): _____ |  |

5. Please check any allergies that apply and describe reaction.

- |  |  |
|--|--|
| <input type="checkbox"/> Animals _____                 | <input type="checkbox"/> Hay Fever _____     |
| <input type="checkbox"/> Pollen _____                  | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Medicines/drugs _____         | <input type="checkbox"/> Food _____          |
| <input type="checkbox"/> Plants _____                  |  |
| <input type="checkbox"/> Other (Please specify): _____ |  |

6. Please check any other health conditions that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Motion Sickness               | <input type="checkbox"/> Nosebleeds         |
| <input type="checkbox"/> Sleep disturbances            | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Wears glasses/contact lenses  |   |
| <input type="checkbox"/> Other (Please specify): _____ |   |

\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

7. Please provide any information that would be helpful for the supervising adult(s) to know in relation to your health, such as special instructions or any activities that should be restricted, etc.

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## **Consent to Emergency Medical Treatment**

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I give permission for \_\_\_\_\_ to receive any necessary medication or treatment prescribed by a physician. In no event will the Buddhist Churches of America, its officers, leaders, counselors or agents be held liable for any first aid rendered or treatments, drugs & medicine or surgical procedures performed pursuant to this consent. In the event of an emergency, every effort will be made to contact the parent or guardian before any medical service is rendered aside from first aid.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date