LEAP Medical Form

CONTACT INFORMATION

Name _____ Birth Date _____

Address _____

Phone _____ Home/Work/Cell (circle one)

Emergency Contact

Name _____ Relationship _____

Best Phone _____ Home/Work/Cell (circle one)

Secondary Phone _____ Home/Work/Cell (circle one)

If participant is under the age of 18:

Parent/Guardian Name _____ E-mail _____

Address _____

Best Phone _____ Home/Work/Cell (circle one)

Secondary Phone _____ Home/Work/Cell (circle one)

Parent/Guardian Name _____ E-mail _____

Address _____

Best Phone _____ Home/Work/Cell (circle one)

Secondary Phone _____ Home/Work/Cell (circle one)

MEDICAL INFORMATION

Primary Care

Physician's Name _____ Phone _____

Does the participant have health insurance? □ Yes □ No

Insurance Company: _____ Policy# _____

Address: _____

Has the participant received a tetanus shot within the last ten years?

□ Yes □ No

Does the participant have allergies? If you check "yes" please describe the allergy, the degree of intensity of reaction, and the treatment.

Medications: □ Yes □ No Description:_____

_____

Foods: □ Yes □ No Description:_____

_____

Insect Bites: □ Yes □ No Description:_____

_____

Other: □ Yes □ No Description:_____

_____

Does the participant carry an epi-pen? □ Yes □ No

If the participant carries an epi-pen, does he/she know how to use it? □ Yes □ No

Please list all surgeries or major injuries including dates:

_____

_____

_____

Please check if participant has experienced any of the following medical problems:

□ ADHD/ADD	□ Epilepsy or Convulsions	□ Mononucleosis
□ Anorexia/Bulimia Nervosa	□ Emphysema	□ Polio
□ Asthma	□ Heart Problems	□ Pneumonia
□ Bleeding or Blood Problems	□ Hepatitis	□ Rheumatic Fever
□ Broken or Dislocated Bone	□ High Blood Pressure	□ Sun Sensitivity
□ Concussion	□ Kidney Problems	□ Thyroid Problems

□ Diabetes □ Severe Menstrual Cramps □ Tuberculosis

□ Psychiatric Illness (if checked, please provide details)

_____

□ Other (if checked, please provide details) _____

_____

_____

Do any illnesses or injuries impact the participant's ability to participate in LEAP? □ Yes □ No

If yes, please provide details _____

_____

Please list all medications the participant takes:

Medication	Dose	Time of Day	Notes/How Often

What medications does the participant need to keep with him/her?

_____

Do any of the participant's medications require refrigeration? If so, please list:

_____

EMERGENCY MEDICAL TREATMENT

Your signature below, or your parent's signature if you are under the age of 18, authorizes emergency medical treatment or medication (like ibuprofen, epinephrine, or anti-histamine).

_____

Corps Member Signature Printed Name Date

_____

Parents Signature Printed Name Date