

**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: | |  | | | | | |

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| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| 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: | |
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|  | |
|  | |

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) | | |  | | |
|  |  | | | | | |
|  |  | | | | | |

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| --- | --- |
| 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 | |
|  |  |  | | |  |  | | | |  | |  |
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| What medications does the participant need to keep with him/her? | | | | | | | | | | | | |
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| --- |
| 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).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Participant Signature |  | Participant Printed Name |  | Date |
|  |  |  |  |  |
|  |  |  |  |  |
| Parent/Legal Guardian Signature |  | Parent/Legal Guardian Printed Name |  | Date |