

# FREEDOMS FOUNDATION AT VALLEY FORGE

## STUDENT MEDICAL INFORMATION FORM

This form consists of FOUR (4) sections. In order to be admitted to the American Leaders Youth Summit, each section needs to be completed with the required signatures and be received by the Freedoms Foundation Education Office prior to the program or be submitted by the participant upon arrival on the Freedoms Foundation campus. **Please also include a photocopy of the student's health insurance card.**

NAME OF PARTICIPANT \_\_\_\_\_

### I. PARENT'S WAIVER

We (I) hereby give permission for the above named student to attend the American Leaders Youth Summit on \_\_\_\_\_ (inclusive dates) to be conducted at Freedoms Foundation at Valley Forge. We (I) hereby release and discharge the Freedoms Foundation at Valley Forge, its officers, agents, instructors, and employees, from any and all claims, demands, suits, actions or causes of action which we (I) may or shall have reason of any illness, injury or accident incurred or suffered by the above named participant at this conference and in the course of travel by any means to and from and while on the premises of the Freedoms Foundation at Valley Forge, no matter how caused or occasioned.

Names of Parents or Guardians (please print) \_\_\_\_\_  
(circle one)

Signature of Parents/Guardians \_\_\_\_\_

Telephone Contacts:

Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_

### II. INSURANCE

Freedoms Foundation does not carry medical insurance to cover participants. All participating students should be covered by personal or family insurance.

We (I) hereby certify, under penalty of perjury, that the above named student is covered by medical insurance.

Names of Parents or Guardians (please print) \_\_\_\_\_

Signature of Parents/Guardians \_\_\_\_\_ Date \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy/Group number \_\_\_\_\_ Expiration Date of Insurance \_\_\_\_\_

Please list emergency number(s) other than those above at which parent, guardian, or another relative may be reached during the conference.

(Please print and indicate relationship to student)

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
(relationship)

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
(relationship)

### III. PARENT'S CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that our (my) child \_\_\_\_\_ becomes ill or sustains an injury while under the supervision of the Freedoms Foundation staff, we (I) hereby give permission to administer first aid for our (my) child's relief. If it is not practical to return our (my) child to us (me), or to receive our (my) instructions for his/her care, consent is given to any licensed physician and/or surgeon to whom our (my) child is taken for treatment, to administer such treatment, drugs, and medicines and to perform such surgical procedures as the licensed physician and/or surgeon shall think the existing emergency requires for the relief of pain, and to preserve our (my) child's life and health. We (I) understand and agree that while the Freedoms Foundation staff may seek medical treatment for our (my) child, we (I) hereby release and discharge the Freedoms Foundation, its officers, agents, instructors, and employees, for any and all demands, suits, actions or causes of actions that we (I) may or shall have by reason of arranging for such medical treatments or from failure to seek such medical treatments.

Name of Parents or Guardians (please print) \_\_\_\_\_

Signature of Parents/Guardians \_\_\_\_\_

### IV. STUDENTS MEDICAL HISTORY

Name of Participant \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

has been examined and is in good health. In addition, the health, history, and immunization records have been reviewed. There are no objections to participating in this conference for health related reasons.

Date of most recent exam \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Date of most recent tetanus toxoid immunization \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Doctor's Telephone \_\_\_\_\_

#### HEALTH HISTORY

*Please provide any information about a student's health history that may impact their participation in the program. This may include health concerns, food and medication allergies (see below), and/or current medications (see below). Attach additional pages if necessary.*

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

Allergies (Hay fever, insect stings, etc.) \_\_\_\_\_

Food allergies \_\_\_\_\_

Medication allergies \_\_\_\_\_

Current Medication taking \_\_\_\_\_