

**APPLICANT: ATTACH TO APPLICATION AND MAIL BY February 1, 2020.**



## STAFF MEDICAL HISTORY

Staff Members Under 18

If you are to attend and participate in the IEFLP Leadership Conference, you and your parent (or guardian) must complete this medical history form. **You cannot attend the Conference if this information is not returned to us.** Kindly supply all requested information.

Please attach a recent photograph at left. PLEASE TYPE OR PRINT.

Last Name	First Name	MI	Sex	Birthdate	Birthplace
Address	City	State	ZIP	Home Phone	
Full Name of person to notify in case of emergency:					Relationship
Address	City	State	ZIP	Work Phone	

Family Doctor	Doctor's Address	City	State	ZIP	Doctor's Phone

### Medical Insurance Information

Policy Holder	Health Plan/Insurance Company
Policy Number	Expiration Date

**1. If you do not have medical insurance, how do you get medical services?**

**2. Is your child experiencing any of the following medical problems:**

- |                                                                                                 |                                                                                           |
|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Asthma <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>                   | Stomach Problems <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>   |
| Blood Disorders (Anemia) <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> | Migraine Headaches <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> |
| Menstrual Disorders <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>      | Seizure Disorder <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>   |

**3. Please list any other ongoing medical problems:**

**4. Does your child have any allergies?**

(Medications, foods, bee stings, plants, Insect bites, etc.) **Yes**  **No**

To what? \_\_\_\_\_

Describe her/his reaction. (In your description indicate if it is mild, moderate, or severe.)

\_\_\_\_\_

How do you treat it? \_\_\_\_\_

Does your child carry an EpiPen®? **Yes**  **No**



Inland Empire Future Leaders Program  
**STAFF MEDICAL HISTORY**  
 Staff Members Under 18  
 (continued)

5. Is your child taking any medications prescribed by a doctor? Yes  No

Is he/she taking any other medications (including over-the-counter medications)? Yes  No

If your child takes any medications, please **make a list of those medications** (prescribed or over-the-counter) that she/he will be taking during the conference. Please attach a list to this form or list them on the back of this form. If your child has an inhaler and a spare, be sure she/he to brings them.

6a. When was your child's last tetanus shot? Month \_\_\_\_\_ Year \_\_\_\_\_

Please attach a copy of his/her vaccination record. If record is not submitted, your child cannot be accepted.

Tetanus shot is good for ten years. If not current, it **MUST** be updated. Contact us if you need a referral to a free clinic.

6b. When was your child's last Measles, Mumps, Rubella (MMR) vaccination?

Month \_\_\_\_\_ Year \_\_\_\_\_

(Current MMR vaccination is required prior to being accepted to attend the IEFLP Conference.)

7. Do your child have limitations to physical exercise? Please explain.

8. Please describe any special dietary needs.

9. Eating disorders can be detrimental to the health of a participant, particularly in the altitude and warm climate at the Conference. Some disorders such as anorexia cannot be accommodated at the Conference. For their personal safety, participants discovered to have eating disorders will be sent home.

Please initial here: \_\_\_\_\_

Parent's/Guardian's Signature	Parent's/Guardian's Printed Name	Date



## Inland Empire Future Leaders Program AGREEMENT & MEDICAL RELEASE

### Staff Form

Staff Members Under 18

I am the parent or legal guardian of \_\_\_\_\_  
who will be participating in activities sponsored by Inland Empire Future Leaders Program. In completing the required medical form, I have provided accurate and complete information about my child's medical record.

I hereby authorize Inland Empire Future Leaders Program, its personnel and representatives, to act for me on \_\_\_\_\_'s behalf in taking such action and securing and authorizing such treatment as they, or any of them, may deem appropriate with respect to any emergency, accident, illness, or similar circumstance arising in connection with the sponsored activity. I agree that Inland Empire Future Leaders, its personnel and representatives shall not have any liability for taking or authorizing any such action or treatment.

I agree to be responsible for, and to pay promptly, any bills for medical, optical, dental or related services, or treatment authorized by Inland Empire Future Leaders, whether or not such services are covered by insurance.

I agree to release and discharge Inland Empire Future Leaders, its personnel and representatives from any liability or demands that might arise in connection with 1) any accident, illness, or injury, or other consequence or event arising from in connection with my son/daughter's participation in the leadership development, or 2) any cause beyond the control of Future Leaders Program, including but not limited to, natural disasters or civil disturbances.

I understand that the IEFLP Leadership Conference takes place at an altitude of 6000 feet. I further understand that the terrain is mountainous and hilly, requiring some hiking. I understand that at times our child will engage in some strenuous physical activity. I am aware that my child must take care to stay hydrated, to wear sunscreen, to use insect repellent, and to protect her/his feet by wearing appropriate footwear (such as tennis shoes) at all times. I understand that he/she may be exposed to typical plants and insects found in a Southern California mountain forest environment.

In completing the required medical form, I have provided accurate and complete information about my child's medical record.

\_\_\_\_\_  
Parent/Guardian Name

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

\_\_\_\_\_  
Date