Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____

DOB: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Learning for Life activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Learning for Life, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with Learning for Life volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Learning for Life activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS

You must designate at least one adult. Please include a telephone number.

1. Name _____ Telephone _____

2. Name _____ Telephone _____

3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____

2. Name _____

3. Name _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Participant's name: _____ Date: _____

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B: General Information/Health History

Full name: _____

DOB: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date**:
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date**:
☐	☐	List any other medical conditions not covered above	

Part B: General Information/Health History

Full name: _____

DOB: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:**_____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**