FFA LEAD 360 CONFERENCE MEDICAL INFORMATION
PLEASE TYPE OR PRINT AND BRING TO CAMP ONSITE REGISTRATION

FFA Members Name _____ Name of FFA Chapter _____

FFA Members Age _____ Grade Level _____ Male or Female _____

Parent/Guardian's Name _____

Home Address _____ Zip _____

Telephone (Home) _____

Telephone of Parent/Guardian (Cell) _____

Telephone of Parent/Guardian (Work) _____

Student's Physician _____

Office Address _____ Zip _____

Telephone of Physician _____

Alternate Contact _____ Relationship _____

Telephone (Home) _____ Telephone (Cell) _____

Student is covered by group or medical insurance: _____Yes _____ No. If yes, complete the following:

Name of Insured _____ Insurance Company _____

Group Number _____ Policy Number _____

Please specifically describe any medical condition that may recur or be a factor in the student's medical treatment. For example: Allergies, Physical Handicap, Convulsions, Medicine Reactions, Blackouts, Disease of any Kind, Heart or Lung Problems, Food Issues, Other:

a._____

b._____

c._____

If currently taking medication, please provide the following information:

a.Name/Dosage of Medications: _____

_____

Please check one of the following and sign your name:

_____ I give permission for immediate medical treatment as required in the judgement of the attending physician.
Notify me and/or any persons listed above as soon as possible.

_____ I give permission for admission to the hospital.

_____ I do **NOT** give permission for medical treatment until parent/guardian has been contacted.

Parent/Guardian's Signature _____ Date _____

(The following to be completed by Camp Staff during onsite Registration)

ASSIGNED CABIN _____ ASSIGNED GROUP COLOR _____