



# HEALTH FORM

[www.arrivefridayleadmonday.com](http://www.arrivefridayleadmonday.com)

## RYLA Conference Health Form

This form enables you to be treated in the unlikely event of an emergency. Please complete it with your doctor if appropriate (and your parents if you are under the age of 18). All information you provide is confidential.

### Personal Information

Social Security Number \_\_\_\_\_

If your mother and father do not live together, with whom do you live? \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

### Insurance Information

**Please note: Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance.**

Are you covered by any hospitalization/medical care policy? \_\_\_\_ Yes \_\_\_\_ No

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

Phone \_\_\_\_\_

Policy or Certificate # \_\_\_\_\_

Does your insurance company require pre-authorization? \_\_\_\_ Yes \_\_\_\_ No

### Medical History

Family Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Emergency Phone \_\_\_\_\_

Date of most recent tetanus booster \_\_\_\_\_

List any food, drug, or insect allergies:

Have you had any serious illness or accidents?

Please give any details on your health that the conference staff and any medical staff should know (including *all* medical conditions, dietary restrictions, and/or special instructions from your doctor). In addition, please indicate what conditions (if any) may affect your participation in physical activity.

Are you currently taking medications? \_\_\_\_ Yes \_\_\_\_ No

If yes, please provide detailed information about each medication, including the reason for the medication, amount and time of each dosage, and possible side effects.

***By submitting this form, I certify that all statements made by me on this form are true to the best of my knowledge, and that I have not withheld any information that would, if disclosed, affect my participation in the conference or any medical treatment.***

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_ By checking here, I agree to the above and understand my typed name serves as a signature.

**If student is under the age of 18:**

***In case of medical emergency during which I cannot be reached, by submitting this form I hereby authorize any medical care necessary for my child. I accept responsibility for medical treatment charges that may be incurred on my child's behalf.***

**Parent/Guardian's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_ By checking here, I agree to the above and understand my typed name serves as a signature.

Please email your completed Health Form to [eopicka@pathmakers-inc.com](mailto:eopicka@pathmakers-inc.com). Failure to complete and email this form will not allow for conference participation.