

**JOSEPH H. PENDLETON  
YOUTH LEADERSHIP CONFERENCE, INC.**

A PATRIOTIC EDUCATION PROGRAM  
of  
*The Military Order of the World Wars*

**HEALTH AND MEDICAL FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**IN CASE OF EMERGENCY, NOTIFY:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
If different from above Street City State Zip

Social Security Account No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ Office: \_\_\_\_\_ FAX: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

**AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR**

THIS FORM MUST BE SIGNED BY PARENT OR GUARDIAN IF PARTICIPANT IS UNDER 18.

I (we), the undersigned parent(s) (or guardian(s)) of the above named minor, do hereby authorize the Military Order of the World Wars Youth Leadership Conference's Medical Officer, or his nominee, as agent for the undersigned to consent to any x-ray, Examination, Anesthesia, Medical or Surgical Diagnosis or treatment and Hospital care which is deemed advisable by, or which is to be rendered under the general or special supervision of a Physician or Surgeon licensed to practice in the State of California.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to care, which the aforementioned Physician, in the exercise of his best judgment may deem advisable. This authorization will be effective from the first through the last day of the Conference, unless sooner revoked in writing and delivered to said agent.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Home Phone No: \_\_\_\_\_

## **MEDICAL HISTORY**

### **FILL IN THE INFORMATION AS COMPLETELY AS POSSIBLE**

Date of last complete physical examination (month and year) \_\_\_\_\_

Has it ever been necessary to restrict your physical activities for medical reasons? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, explain in full: \_\_\_\_\_

\_\_\_\_\_

Are you aware of any current health problems? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, explain : \_\_\_\_\_

\_\_\_\_\_

Are you now under medical care or regularly taking medications? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, explain: \_\_\_\_\_

\_\_\_\_\_

Has there been any significant surgery injury, illness or change in health status since your last physical examination?

YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, explain: \_\_\_\_\_

\_\_\_\_\_

## **EMERGENCY MEDICAL INFORMATION**

If subject to any of the following, check the box and explain in detail:

Allergy to any plant, food or animal: \_\_\_\_\_

Allergy to any drug or insect toxin: \_\_\_\_\_

Any condition requiring regular medication or diet or special care \_\_\_\_\_

\_\_\_\_\_

Asthma \_\_\_\_\_ Convulsions \_\_\_\_\_ Heart Trouble \_\_\_\_\_ Diabetes \_\_\_\_\_ Bleeding Disorder \_\_\_\_\_

Other, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_