# Area III FFA Association
# Health History Form

***INSTRUCTIONS**: Complete the entire form and bring to the Area Leadership Conference*. **Date:** June 20-22, 2022

Area: _____ Chapter: _____ Name: _____

Male: ____ Female: ____ Date of Birth: _____ Age: _____ Cell Phone #: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Parent/Guardian Work #: _____

Parent/Guardian Cell #: _____ Parent/Guardian Cell #: _____

Physical Limitations or Handicaps:_____

**Relative or neighbor to be contacted in case parent/guardian cannot be reached in an emergency:**

Name: _____ Relation: _____ Phone: _____

**SPECIAL MEDICATIONS** are being sent with minor in quantity to meet his/her needs during this event. ____Yes ____No

If YES, list the name of the drug(s) and/or medication, along with the name and phone number of the prescribing physician, dosage, consumption rate and interval:_____

_____

**Please check "over the counter" mediation which may be administered as deemed necessary:**

__ Acetaminophen (Tylenol) __ Motrin (Ibuprofen) __ Pepto Bismol __ Neosporin __ Benadryl __Calamine/Caladryl __ Any as needed

**Special Dietary Needs or Conditions:** *(i.e. Food Allergies, Diabetes, etc.)* _____

**Health History:** *(Please check any of the following that apply)*

___Frequent Ear Infections ___Heart Defect/Disease

___Convulsions ___Diabetes

___Bleeding/Clotting Disorders

**Allergies:**

___ Hay Fever ___Ivy Poisoning

___Insect Stings ___ Penicillin

___Other

Operations or Serious Injuries: *(List along with approximate date)* _____

_____

Chronic or Recurring Illness: _____

_____

Name of Family Physician: _____ Phone: _____

Medical Insurance Carrier: _____ Policy Number: _____

Date of last Tetanus Immunization: _____

*Health History is correct as far as I know.* **Authorization for Treatment**: *In the event that my child becomes incapacitated, I hereby give permission to have emergency first aid administered by any qualified person in case of illness and/or injury and to be transported by the most expedient means of conveyance to the nearest available physician, hospital or clinic and receive treatment as is medically prescribed by physician(s). In case of extreme illness and/or injury, I do further agree that the Area III FFA Association and their employees or agents, individually or collectively, shall not be held responsible or liable for personal injury or loss resulting from participation in the State Leadership Conference.*

Parent/Guardian Printed Name: _____ Relation: _____

Parent/Guardian Signature: _____ Date: _____

***The Area III FFA Association considers this privileged information. It will be used for medical reasons only.***