

# Delegate Medical Form

Lodge # \_\_\_\_\_

<b>To be filled out by parent/guardian or adult participant. Please print in ink.</b>		
<b>Delegate Information</b>		
<b>Name:</b>	<b>Email:</b>	
<b>Address:</b>		
<b>City</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone: ( )</b>	<b>Date of Birth:</b>	
<b>Circle One:</b>	<b>Ordeal</b>	<b>Brotherhood</b>
		<b>Vigil</b>
<b>Primary Emergency Contact</b>		
<b>Name:</b>	<b>Relationship:</b>	
<b>Day Phone: ( )</b>	<b>Evening Phone: ( )</b>	
<b>Secondary Emergency Contact</b>		
<b>Name:</b>	<b>Relationship:</b>	
<b>Day Phone: ( )</b>	<b>Evening Phone: ( )</b>	
<b>Medical Information</b>		
<b>Do you:</b> <input type="checkbox"/> have any medical restrictions? <input type="checkbox"/> currently take any medications? <input type="checkbox"/> have any dietary restrictions?	<b>Explain:</b>	
<b>Health Insurance Company:</b>	<b>Policy #:</b>	
<b>Have or subject to:</b> <input type="checkbox"/> Convulsions <input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Allergy to medication, food, plant, animal, or insect <input type="checkbox"/> A condition requires special care, medication or diet <input type="checkbox"/> NONE OF THE ABOVE APPLY <input type="checkbox"/> Other	<b>Explain:</b>	
<input type="checkbox"/> <b>Any condition now requiring regular medication?</b>	<b>Name of medication:</b>	
<b>Last Tetanus toxiod date:</b>		
<p>I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical personnel dictates.</p> <p><b>In case of emergency</b>, I understand every effort will be made to contact me (an adult, my spouse or next of kin). In the event, I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including but not limited to hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult)</p>		
<b>Participant</b>		<b>Parent or Guardian</b>
<b>Signature:</b>	<b>Signature (if participant under 18 years):</b>	
<b>Date: _____</b>	<b>Date: _____</b>	