



## FFA Association Minor's Release and Health History Form



**INSTRUCTIONS:** Complete the entire form and return prior to travel.

Area: \_\_\_\_\_ Chapter: \_\_\_\_\_ Program Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Parent or Guardian: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physical Limitations or Handicaps: \_\_\_\_\_

**SPECIAL MEDICATIONS** are being sent with minor in quantity to meet his/her needs during camp.  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 medication which conference personnel/advisor may administer 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, ect.) If notified in advance, the Center is happy to accommodate any special needs. \_\_\_\_\_

**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: \_\_\_\_\_

Are your immunizations current and on record at your school?  Yes  No

Date of last Tetanus Immunization: \_\_\_\_\_

*The FFA Association considers this privileged information. It will be used for medical purposes only. Please make a copy of insurance card and attach to this form*

IF, IN THE JUDGEMENT OF ANY REPRESENTATIVE OF THE SCHOOL, THE ABOVE STUDENT NEEDS IMMEDIATE CARE AND TREATMENT AS A RESULT OF ANY INJURY OR ILLNESS, I DO HEREBY REQUEST, AUTHORIZE, AND CONSENT SUCH CARE AND TREATMENT AS MAY BE GIVEN SAID STUDENT BY ANY MEDICALLY QUALIFIED REPRESENTATIVE. I DO HEREBY, AGREE TO INDEMNIFY AND SAVE HARMLESS THE SCHOOL AND ANY SCHOOL REPRESENTATIVE FROM ANY CLAIM BY ANY SUCH PERSON OF SUCH CARE AND TREATMENT OF SAID STUDENT.

\_\_\_\_\_  
STUDENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE