

PLEASE
ATTACH
PHOTOGRAPH
HERE

STAFF MEDICAL HISTORY

Adult Form

If you are to attend and participate in the IEFLP Leadership Conference and training activities, you must complete this medical history form. **You cannot participate in any activities if this information is not returned to us.** Kindly supply all requested information. Please attach your recent, clear head shot photograph at left. PLEASE TYPE OR PRINT.

Last Name	First Name	MI	Sex	Birthdate	Birthplace
Address	City	State	ZIP	Home Phone	
				()	
Full Name of person to notify in case of emergency:					Relationship
Address	City	State	ZIP	Emergency Phone	
				()	

Family Doctor	Doctor's Address	City	State	ZIP	Doctor's Phone
					()

Medical Insurance Information

Policy Holder	Health Plan/Insurance Company
Policy Number	Expiration Date

1. If you do not have medical insurance, how do you get medical services?

2. Are you experiencing any of the following medical problems:

Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stomach Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Disorders (Anemia)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Migraine Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Menstrual Disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizure Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>

3. Please list any other ongoing medical problems:

4. Do you have any allergies? (Medications, foods, bee stings, plants, Insect bites, etc.) Yes No

To what? _____

Describe your reaction. (In your description indicate if it is mild, moderate, or severe.)

How do you treat it? _____

Do you carry an EpiPen®? Yes No



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(Continued)

5. Are you taking any medications prescribed by a doctor? Yes No

Are you taking any other medications (including over-the-counter medications)? Yes No

If you take any medications, please make a list of those medications (prescribed or over-the-counter) that you will be taking during the conference. Please attach a list to this form or list them on the back of this form. If you have an inhaler and a spare, be sure to bring them with you.

6. When was your last tetanus shot? Month _____ Year _____

Please attach a copy of your vaccination record. If record is not submitted, you cannot be accepted.

Tetanus shot is good for ten years. If not current, it **MUST** be updated. Contact us if you need a referral to a free clinic.

7. Do you have limitations to physical exercise? Please explain.

8. Please describe any special dietary needs.

9. Eating disorders can be detrimental to the health of a participant, particularly in the altitude and warm climate at the Conference. Some disorders such as anorexia cannot be accommodated at the Conference. For their personal safety, participants discovered to have eating disorders will be sent home.

Please initial here: _____

Staff Member's Signature	Print Name As Signed	Date

Important Note: If you are not 18 years of age by February 1, you must submit the medical forms for staff members under 18 years of age. Please download those forms from our web site: www.iefl.org.