

MOWW® | YLC & YES STUDENT MEDICAL TREATMENT

Youth Leadership Conference (YLC) / Youth Education Seminar (YES)

EVENT NAME & LOCATION: _____

Refer to YLC/YES Schedule

DATES: _____

Refer to YLC/YES Schedule

NOTE: This Student Application and the annual YLC-YES Schedule are at <https://www.moww.org>, "Patriotic Education Programs for Youth." Individual YLC and YES events may have an additional application requirements specific to their venue, please contact the applicable event director for further information (YLC/YES Director contact information is on the annual YLC/YES Schedule).

Note: The information contained in these medical reports will be handled with extreme care and will only be used by the event director medical officer or designated event staff cited above or authorized medical personnel. Application material will be destroyed 2 years after the event.

PART A. AUTHORIZATION CONSENTING TO THE TREATMENT OF A MINOR (Please print clearly)

I (we) the undersigned parent/legal guardian of the named student minor below do hereby authorize the Event Organization and the Military Order of the World Wars, Inc.®, the Youth Leadership Conference's Director or their designated staff member(s) as agent(s) 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 any physician licensed to practice in the Event location/state. 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 provide care, which the aforementioned physician, in the exercise of his/her best judgment deemed advisable. This authorization will be in effect for the duration of the cited event.

Except for a case of substantiated gross negligence or worse, the undersigned hereby releases and contracts to hold harmless the Event Organization, Youth Leadership Conference's/Youth Education Seminar's Director and staff, and MOWW, Inc., from any and all liability and/or responsibility for the child's welfare, well-being and control for the period of the conference including the day of departure and the day of return if the chapter provides transportation until the day of return.

Student Name: _____

First, Middle Initial, Last, Suffix

Parent/Legal Guardian relationship to student

PART B. PHYSICIAN, INSURANCE & ALTERNATE CONTACT (please print clearly)

Family Physician: _____

First, Middle Initial, Last, Suffix

; Phone: _____

Office

- Address: _____

Address: Number, Street, City, State, ZIP Code

- _____

Email

Home Phone

Cell Phone

Health Insurance Company: _____

First Name, Middle Initial, Last Name, Suffix

; Policy #: _____

- Address: _____

Address: Number, Street, City, State, ZIP Code

- _____

Email

Home Phone

Cell Phone

PART C. STUDENT'S MEDICAL HISTORY (please print clearly)

1. Does student have any of the following conditions? (Indicate "Yes" or "No" at each underscore)

Asthma: _____

Convulsions: _____;

Heart Trouble: _____;

Diabetes: _____

Bleeding Disorders: _____;

Other: _____

If "Yes" to any condition listed above, please explain:

MOWW® | YLC & YES STUDENT MEDICAL TREATMENT

Youth Leadership Conference (YLC) / Youth Education Seminar (YES)

2. Does student have any of the following allergies (Indicate "Yes" or "No" at each underscore)

Allergy to any plant, food, or animal: _____ Allergy to any drug or insect toxin: _____

Allergies to bug spray or sunburn lotion: _____ Regular medication or diet or special care: _____

If "Yes" to any above, please explain:

3. Date of student's last complete physical examination: _____
Date: Day-Month-Year

4. Has the student had significant surgery, injury, illness or change in health status since their last physical?

- Yes / No (*circle one*). If "Yes," please explain:

5. Has it ever been necessary to restrict student's physical activities for medical reasons

- Yes / No (*circle one*). If "Yes," please explain:

6. Are you aware of any other current health problems?

- Yes / No (*circle one*). If "Yes," please explain:

7. Is student now under medical care or regularly taking medications?

- Yes / No (*circle one*). If "Yes," please explain:

8. **Date of immunizations:**

Tetanus: _____; Diphtheria: _____; Polio: _____; Mumps: _____

Measles: _____; Rubella: _____; Pertussis: _____; Other: _____

The undersigned certifies the information above is true and correct to the best of the undersigned's knowledge:

Parent/Legal Guardian Name: _____
First, Middle Initial, Last, Suffix

Parent/Legal Guardian Signature _____ Date: Day-Month-Year