HEALTH STATEMENT FOR FFA EVENTS

To be completed and signed by parents/guardians of all FFA EVENT participants 18 years of age and under.

Name _____Birth Date_____Sex_____Age_____

Parent's Name_____Phone (day) _____

Parent's Address _____Phone (evening) _____

Second Parent's Name_____Phone (day)_____

Parent's Address _____Phone (evening) _____

Health History

(Attach a separate sheet if necessary)

Recommendation and restrictions while at FFA Event (Reporting such conditions will not prevent a person from attending event and will be kept confidential by staff): _____

_____

*Medications and Dosing Schedule the student will be bringing:*_____

_____

Over the counter medications NOT to be take: _____

*Dietary Restrictions:*_____

*Allergies:*_____

*Anytime health care outside the community is needed, parents/guardians will be notified. If you wish to be notified in any other circumstances, please list :*_____

*My child (Name)*_____*has my permission to attend organized events thru the FFA: YES NO*

*Activities my child **does NOT** have my permission to participate in* _____

_____

I understand that at FFA activities, participants will be closely supervised and that if a serious illness or injury develops medical and/or hospital care will be given. However, the staff and organization will not be held responsible in case of accidental injury or illness. Members must provide their own health insurance: SDFF does not provide medical insurance for the members.

I further understand that in case of serious illness or injury we will be notified. If it is impossible to contact us, we give permission for emergency treatment or surgery as recommended by attending physician. Insurance/payment of medical service received is the responsibility of the individual attending the FFA activity, their parent or guardian.

I herby giver permission to the medical personnel selected by the FFA director to order x-rays, routine tests, treatment, and necessary transportation for my child. In event I cannot be reached in an emergency, I herby giver permission to the physician selected by the FFA Director to secure and administer treatment, including hospitalization, for my child as named above.

Signature of Parent or Guardian_____Date:_____