IOWA FFA LEADERSHIP CONFERENCE CONSENT/WAIVER FORM

Chapter #: IA_____

Student Name_____
First M.I. Last

Age_____ Birthdate_____ Gender: M F

Address_____

Height_____ Weight_____ Hair Color_____ Eye Color_____

Mother/Guardian Name_____ Daytime Phone_____

Father/Guardian Name_____ Daytime Phone_____

Other Contact Name_____ Nighttime Phone_____

Allergic To Bee Stings That Require Medication: ( ) Yes ( ) No

Allergies to Drugs: ( ) Yes ( ) No If yes, please list_____

Allergies to Foods: ( ) Yes ( ) No If yes, please list_____

Physical Handicaps: ( ) Yes ( ) No If yes, please list_____

Respiratory Problems/Asthma: ( ) Yes ( ) No If yes, please list_____

Vision/Hearing Problems: ( ) Yes ( ) No If yes, please list_____

Special Dietary Needs/Restrictions: _____

Dates of Last Immunizations: MMR_____ TB_____ Tetanus_____

Are you presently taking any medicines? ( ) Yes ( ) No If yes, please list_____

Special Medical Conditions/ Other Pertinent Information including surgeries, hospitalizations, etc: (add additional page if necessary)_____

Insurance Company_____ Subscribers Name_____

Insurance Company Address_____

Policy Number_____ Type_____ Group Number_____

Family Doctor's Name_____ Phone #_____

I hereby authorize in advance any medical treatment required by above student.

Parent's Signature:_____ Picture (Optional):

Date:_____

Parent's Printed Name:_____