American Legion Auxiliary ~ Hoosier Girls State

Medical Record and Consent Form

(To ensure Delegate's participation, this form must be fully completed as instructed, signed, and turned in day of registration. Please type or print clearly.)

SECTION 1 -DELEGATE INFORMATION

Name _____

In case of emergency, Contact: _____

Primary Phone: (_____) _____ Secondary Phone: (_____)_____

Address: _____

SECTION 2 - PARENT OR GUARDIAN INSURANCE INFORMATION

(Staple a photo-copy of the patient's insurance card and the patient's prescription card, if separate to this form)

Name: _____Home Phone: (_____)_____

(*If different than above)* Address: _____

_____

Insurance Company Name: _____ Phone: (_____)_____

Address: _____

Policy Holder's Name: _____

Plan #: _____ Group #: _____ Policy #: _____

SECTION 3 – Parent or Guardian Consent for Emergency Treatment

I, _____, parent and/or legal guardian of _____

Parent or Guardian Name ALA HGS Delegate's Name

hereby give my permission for any and all emergency treatment deemed necessary by a physician on my daughter during the period of time from June 18, 2017 to June 24, 2017.

_____

Signature of Parent/Guardian

Section 4 – Physician and Medical Information *(Please be aware this is a very fast paced – strenuous week. If this creates a problem, please decline this opportunity)*

Name of Physician: _____ Phone: (_____)_____
Address: _____
City: _____ State: _____ Zip Code: _____

Check any abnormalities or diseases of the:

____ Heart ____Diabetes ____ Asthma ____ Menstrual ____ Psychological
____ Abdominal ____ Lungs ____ Eyes ____ Ears ____ Extremities
____ Skin ____Throat ____ Allergies (food or medicine)

If any are checked, please explain: _____
_____

List all medical and/or food allergies: _____
_____

List all recent illnesses and/or injuries: _____
_____

All vaccinations current? _____ Yes _____ No If no, please correct.

SECTION 5 – Prescription and Over the Counter Medications

The named Delegate has my permission to take all prescribed medications **without** the assistance of the medical staff at ALA HGS during the time she is in the program. **Any exceptions to this are listed here** and comprise those medications the ALA HGS staff is permitted to assist with the dispensing of for the Delegate's protection.

_____
_____

I grant permission for the ALA HGS medical staff to dispense over the counter medications to my child as they assess necessary during her stay at HGS. These over the counter medications will include but are not limited to Tylenol Advil, Motrin, Benadryl etc. **Any exceptions to this are listed here**. (ie. Allergies, reactions to medications)

The undersigned parent/guardian of _____, a minor, does hereby certify that all of the medical information listed above is true to the best of my knowledge. I authorize the American Legion Auxiliary Hoosier Girls State Staff to seek medical care if necessary to the above named minor.

Signature of Parent/Guardian: _____