American Legion Auxiliary Volunteer Girls State Medical History and Treatment Consent Form

Name _____ Date of Birth _____

Address _____

Parent/Guardian Name(s) _____

Home or Work Phone _____ Cell Phone _____

It is the goal of ALA VGS that every attendee enjoys her experience as much as possible. However, the following must be completed in its entirety and honestly to maximize that goal. The following information is not meant to exclude an attendee from certain activities, only to provide appropriate treatment in a time of medical need. Answers to these questions will be shared only to counselors with immediate contact to the attendee, as deemed necessary by the Nurse Practitioner/Registered Nurse on staff.

Circle all that apply with explanation

ACL/MCL Injury: Surgery (Y/N) Date:
Brace needed (Y/N) When?
ADD/ADHD
Anorexia/ Bulimia
Anxiety/Panic Attacks
Asthma: (Mild Moderate Severe):
Environmental/Exercise Induced
Cancer
Chicken Pox/Shingles
Cystic Fibrosis
Depression
Diabetes (Insulin Dependent/Non-Insulin Dependent)
Dizziness/Lightheadedness/Fainting
Environmental Allergies
Crohns Disease/Ulcerative Colitis
Chronic Headaches/Migraines
Head Injury/Seizure Disorder
Heart Murmur or Abnormality
Hepatitis (A/B/C) or liver abnormality
Homesickness
Hypertension
Hypoglycemia (low blood sugar)
Kidney/Bladder Problems/Kidney Stones
Mononucleosis
Severe Menstrual Cramps/PCOS
Scoliosis
Skin Disorder
Sickle Cell Anemia
Systemic Lupus Erythematosus
Thyroid Disorder
Vision Impairment/Corrective Lenses

Conditions or physical limitations not previously mentioned:

_____

_____

Allergies (drug, food, environmental)

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

Current Prescription Medications/Inhalers (including those only taken as needed)

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____
4. _____ Dosage: _____ Frequency: _____

YOU MUST BRING ALL MEDICATIONS AND INHALERS WITH YOU, EVEN IF YOU TAKE THEM ONLY ON AN AS NEEDED BASIS!

Surgical History (include date): _____

_____

Primary Care Provider Name: _____ Phone Number: _____

Consent for Treatment

I, _____, parent/legal guardian of _____ certify this attendee is in good physical condition and give permission for her to receive any and all emergency treatment deemed necessary by medical personnel during ALA VGS in case of accident or illness, including transport to a local medical facility. I also grant permission for minor treatment and/or administration of over the counter medications (e.g. Tylenol, antacids, throat lozenges) by the ALA VGS Staff, nurse practitioner/registered nurse on staff, and/or infirmary staff on the Lipscomb University campus.

Parent/Guardian Signature: _____ Date: _____

Insurance Information

Policy Holder Name: _____ Employer: _____

Insurance Provider (Company): _____

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

Please attach a copy of the front/back of your insurance card to this form. You will NOT have access to a copier at registration.

☐ Check here if not insured