

American Legion Auxiliary Volunteer Girls State

Medical History and Consent Form

Citizen Name _____ Date of Birth _____

Address _____

Parent/Guardian Name(s) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Emergency Contact _____ Relationship _____

*If not available in an emergency, please contact: _____ Relationship _____

Home Phone: _____ Cell Phone _____

It is the goal of ALA VGS that every citizen 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 a citizen 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 citizen, as deemed necessary by the Nurse Practitioner/Registered Nurse on staff.

Medical History

Please circle all that apply with explanation:

Abdominal pain (not related to menstrual cycle)
ACL/MCL Injury
ADD/ADHD
Anorexia/ Bulimia
Anxiety/Panic Attacks
Asthma: Allergen/Environmental or Exercise Induced (Mild Moderate Severe)
Cancer
Chicken Pox
Chronic Pain
Cystic Fibrosis
Depression/Bipolar/Homesickness
Diabetes (Insulin Dependent/ Non-Insulin Dependent)
Dizziness/Fainting Spells
Environmental Allergies
Gastroesophageal Reflux Disease
Headaches/Migraines
Head Injury
Hearing Impairment
Heart Murmur or Abnormality
Hepatitis (A/B/C)
Hypertension
Hypoglycemia
Inflammatory Bowel Disease (Crohns or Ulcerative Colitis)
Kidney/Bladder Problems
Menstrual Disorder/Polycystic Ovarian Syndrome/Severe Menstrual Cramps
Mononucleosis
Obsessive Compulsive Disorder
Scoliosis
Seizure Disorder
Skin Disorder/Eczema
Sickle Cell Anemia

Sleep Apnea
Systemic Lupus Erythematosus
Thyroid Disorder
Vision Impairment/Corrective Lenses

***Please add any conditions or physical limitations not listed above:

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):

Medical Practitioner Name: _____ Phone Number: _____

Clinic Name and Address: _____

Consent for Treatment

I, _____, parent/legal guardian of _____ certify this citizen 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. I also grant permission for minor treatment and/or administration of over the counter medications (e.g. Tylenol, antacids, throat lozenges, etc.) by the ALA VGS Staff, Registered Nurse on staff, or infirmary campus staff.

Signature: _____ Date: _____

Insurance Information

Company Name: _____ Phone Number: _____

Company Address: _____

Policy Holder Name: _____ Employment: _____

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

You must attach a copy of the front and back of your insurance card to this form.

Copying facilities will not be available at registration

Please check: _____ This citizen is not currently insured.