
AMERICAN LEGION AUXILIARY BUCKEYE GIRLS STATE

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MEDICAL RECORD AND CONSENT FORM

*This form must be fully completed as instructed, **signed**, and returned in the large, self-addressed envelope enclosed in the Delegate's Packet by **June 1, 2008**. Please type or print clearly.*

SECTION 1 – Delegate Information

Name _____
Last, First and M.I.

In case of emergency, contact – Primary (_____) _____ Secondary (_____) _____
Area Code Area Code

Mailing Address _____
Street, Route, Apartment, PO Box, etc.

City _____ Zip Code _____ Date of Birth ____/____/____
Zip + 4 Ex. "01/01/08"

SECTION 2 – Parent or Guardian Insurance Information (Staple a photo-copy of the patient's insurance card)

Name _____ Home Phone (_____) _____
First and Last Name Area Code

(If different than above) Mailing Address _____
Street, Route, Apartment, PO Box, etc.

City _____ Zip Code _____
Zip + 4

Insurance Company Name _____ Telephone (_____) _____
Area Code

Insurance Company Address _____

Policy Holder's Name _____ Social Security # _____

Policy Holder's Place of Employment _____

Plan Number _____ Group Number _____ Policy Number _____

SECTION 3 – Parent or Guardian Consent for Emergency Treatment

*****THIS SECTION MUST BE SIGNED BY PARENT/GUARDIAN TO ENSURE DELEGATE'S PARTICIPATION*****

I, _____, parent and/or legal guardian of _____,
Parent or Guardian Name BGS 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 15, 2008** to **June 21, 2008**. _____
Signature of Parent/Guardian

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