American Legion Auxiliary
Buckeye Girls State
Post Office Box 2760
Zanesville, Ohio 43702-2760
ala_dean@rrohio.com
www.buckeyegirlsstate.org
(740) 452-8245 fax (740) 452-2620

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, 2011**. 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. "01/01/11"

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 _____

**SECTIONS 3 AND 5 MUST BE SIGNED BY PARENT/GUARDIAN,
SECTION 4 BY PARENT/GUARDIAN OR PHYSICIAN,
TO ENSURE DELEGATE'S PARTICIPATION**

SECTION 3 – Parent or Guardian Consent for Emergency Treatment

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 12, 2011** to **June 18, 2011**. _____
Signature of Parent/Guardian

Continued on back

SECTION 4 – Physician and Medical Information

If a physical has been completed within the last year by a physician, the parent may sign in this section. If not, a physician must complete and sign in this section.

Family Physician _____ Telephone (_____)_____
Area Code

Physician Address _____

Does the Delegate named on the front have (or in the past had) any of the following: (√ if yes)

☐ Medical Illness(es) ☐ Physical Disabilities ☐ Uses crutches, wheelchair, etc.

☐ Emotional Problems ☐ Drug Abuse ☐ Alcohol Use/Abuse

If yes, explain _____

_____

List all allergies (including food allergies)_____

List all medication taken at this time _____

List all recent illnesses and/or injuries _____

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

Parent/Guardian or Physician Signature Required _____

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 BGS during the time she is in the program. **Any exceptions to this are listed here** and comprise those medications the BGS staff is permitted to assist with the dispensing of for the Delegate's protection. _____

_____

My signature also grants permission for the BGS medical staff to dispense over the counter medications to my child as they assess necessary during her stay at BGS. These over the counter medications will include but are not limited to Tylenol, Advil, Motrin, Lomotil, Benadryl, etc. **Any exceptions to this are listed here**. (ie. allergies, reactions to medications) _____

_____

Parent/Guardian Signature Required _____

SECTION 6 – For BGS Medical Staff Use Only After Arrival

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