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

# MEDICAL RECORD AND CONSENT FORM

***READ CAREFULLY:*** *This form (includes front and back) must be* ***completed*** *as instructed;* ***signed****, and* ***returned*** *in the large, self-addressed envelope enclosed in the Delegate's Packet by* ***June 1, 2019.***
*Please type or print clearly.*

## SECTION 1 – Delegate Information

Delegate Name ______________________________________________
*Last, First and Middle Initial*

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

City ______________________ Zip Code ____________ Date of Birth _____/_____/_______
Zip + 4 Ex. "01/01/2019"

## SECTION 2 – Parent/Guardian Contact AND Insurance AND Prescription Information

Emergency contact info Name; Parent/Legal Guardian ______________________________

Parent/Guardian Primary Phone (______)______________ Secondary Phone (______)______________
Area Code Area Code

Mailing address; if different than Delegate's ______________________________
State, Route, Apartment, PO Box, etc.

City ______________________________ Zip Code ______________
Zip + 4

**Attach** COPY of **FRONT** AND **BACK** of Insurance and Prescription Card in the Space Below

*FRONT* *BACK*

## SECTION 3 – Parent/Guardian Consent for Emergency and First Aid Treatment

I, ______________________________, parent and/or legal guardian of Buckeye Girls State Delegate
Parent or Guardian Name

______________________________, hereby give my permission for any and all urgent and/or emergency
BGS Delegate's Name

treatment deemed necessary by a healthcare professional should the need arise. Permission is also granted for non-emergency first aid by American Legion Auxiliary Buckeye Girls State staff and/or nurse for my daughter during the period of June 16-22, 2019. ______________________________
Signature of Parent / Legal Guardian

## SECTION 4 – Primary Care Provider, Medical History, and Current Health Information

**Continued on back**

**NOTE:** The delegate must have had a physical examination by a licensed healthcare provider within the last year.

Primary Care Provider ______________________________ Phone (_____) ______________
Area Code

Primary Care Provider Address ______________________________ Date of last physical exam ________

**Does the Delegate have, or ever had, any of the following medical conditions?** (Check all that apply)

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | ___ | ___ | Seizures | ___ | ___ | Hepatitis | ___ | ___ | Dental Pain, Surgery | ___ | ___ |
| Asthma | ___ | ___ | Anxiety | ___ | ___ | Self-harm | ___ | ___ | Prosthesis | ___ | ___ |
| Concussion | ___ | ___ | Loss of Consciousness | ___ | ___ | Back Pain, Injury, Surgery | ___ | ___ | Uses Wheelchair | ___ | ___ |
| Alcohol Use | ___ | ___ | Drug Abuse | ___ | ___ | Ear, Nose, Throat Problems | ___ | ___ | Eating Disorder | ___ | ___ |
| Broken Bones | ___ | ___ | High Blood Pressure | ___ | ___ | Digestive Tract Problems | ___ | ___ | Visual Problems | ___ | ___ |
| Fainting | ___ | ___ | Heart Problems | ___ | ___ | Joint Pain, Injury, Surgery | ___ | ___ | Allergies | ___ | ___ |
| Uses Crutches | ___ | ___ | Requires Accommodation | ___ | ___ | Psychiatric Condition(s) | ___ | ___ | Dizziness | ___ | ___ |
| Depression | ___ | ___ | Other | ___ | ___ | Please Describe ______________________ | | | | | |

Explain all above **"YES"** responses: ______________________________________________

______________________________________________

Are you currently under the care of a healthcare professional? If yes, explain: ______________________

______________________________________________

Are you taking any prescription and/or over the counter drugs? If yes, for what condition? List drug, dose, frequency and last dose. ______________________________________________

List all surgeries and year. ______________________________________________

Are all vaccinations up to date? Yes _____ No _____.

**SECTION 5 – Administration of Prescription and/or Over-The-Counter Medications**

The named Delegate has my permission to take all of her regular, prescribed, and over-the-counter medications during this BGS session **without** the assistance of the BGS staff. List exceptions that, for the protection and well-being of the Delegate, must be administered by the BGS clinic staff. ______________________

______________________________________________

I grant permission for the BGS health care staff to dispense over-the-counter oral and/or topical medications to my child as assessed as necessary during her stay at BGS. These over-the-counter medications may include, but are not limited to: acetaminophen, Imodium, hydrocortisone cream, ibuprofen, anti-nausea liquid, antihistamines, cold and flu medications, triple-antibiotic ointment/cream, and etc. List exceptions here: ______

______________________________________________

I verify, for the good of the Delegate, that the medical information provided above is complete, correct and true to the best of my knowledge.

Delegate's Parent and/or Guardian ______________________________ Date _______/_____/_____
Signature

**SECTION 6 – For BGS Clinic Staff Care Notes** ______________________________________________

______________________________________________

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