



**American Legion Auxiliary**  
 Buckeye Girls State      dean@alaohio.org  
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 Zanesville, Ohio 43702-2760      (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, 2018**.  
 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. "01/01/2018"

**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 10-16, 2018. \_\_\_\_\_

Signature of Parent //Legal Guardian

**Continued on back**

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

**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** \_\_\_\_\_