American Legion Auxiliary
Buckeye
Girls State

American Legion Auxiliary
Buckeye Girls State
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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 **May 1, 2022.***
Please type or print clearly and legibly.

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* *PRESCRIPTION CARD*

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 12-18, 2022. _____
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 _____ COVID Vaccine ____Yes ____No # of doses ____

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 _____

_____

_____