

American Legion Auxiliary Volunteer Girls State

Medical Record and Consent Form

Citizen Name _____ Date of Birth _____
 Address _____
 Parent/Guardian Name(s) _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Name of Emergency Contact _____ Relationship _____
 *If not available in an emergency, please contact: _____ Relationship _____
 Home Phone: _____ Cell Phone _____

It is the goal of ALA VGS that every citizen enjoys her experience as much as possible. However, the following must be completed in its entirety and honestly to maximize that goal. The following information is not meant to exclude a citizen from certain activities, only to provide appropriate treatment in a time of medical need. Answers to these questions will be shared only to counselors with immediate contact to the citizen, as deemed necessary by the Registered Nurse on staff.

Personal History

Please circle all that apply with explanation:

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|--|
| Abdominal pain (not related to menstrual cycle) |
| ACL/MCL Injury |
| ADD/ADHD |
| Anorexia/ Bulimia |
| Anxiety/Panic Attacks |
| Asthma: Allergy/Environmental or Exercise Induced (Mild Moderate Severe) |
| Cancer |
| Chicken Pox |
| Chronic Pain |
| Depression/Bipolar/Homesickness |
| Diabetes (Insulin Dependent/ Non-Insulin Dependent) |
| Dizziness/Fainting Spells |
| Ear Infections |
| Environmental Allergies |
| Headaches/Migraines |
| Head Injury |
| Heart Murmur or Abnormality |
| Hepatitis (A/B/C) |
| Hypertension |
| Hypoglycemia |
| Inflammatory Bowel Disease |
| Kidney/Bladder Problems |
| Menstrual Disorder/Polycystic Ovarian Syndrome/Severe Menstrual Cramps |
| Mononucleosis |
| Obsessive Compulsive Disorder |
| Scoliosis |
| Seizure Disorder |

| |
|--------------------|
| Skin Disorder |
| Sickle Cell Anemia |
| STD |
| Thyroid Disorder |
| Vision Impairment |

***Please add any conditions or physical limitations not listed above:

Allergies (drug, food, environmental)

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

Current Prescription Medications/Inhalers (including those only taken as needed)

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____
4. _____ Dosage: _____ Frequency: _____

*****YOU MUST BRING ALL MEDICATIONS AND INHALERS WITH YOU, EVEN IF YOU TAKE THEM ONLY ON AN AS NEEDED BASIS!*****

Surgical History (include date):

Medical Practitioner Name: _____ Phone Number: _____
 Clinic Name and Address: _____

Consent for Treatment

I, _____, parent/legal guardian of _____ certify this citizen is in good physical condition and give permission for her to receive any and all emergency treatment deemed necessary by medical personnel May 25-31, 2008 in case of accident or illness. I also grant permission for minor treatment and/or administration of over the counter medications (e.g. Tylenol, antacids, throat lozenges, etc.) by the Volunteer Girls State Staff, Registered Nurse on staff, or infirmary staff on the MTSU campus.

Signature: _____ Date: _____

Insurance Information

Company Name: _____ Phone Number: _____
 Company Address: _____
 Policy Holder Name: _____ Employment: _____
 Plan #: _____ Group #: _____ Policy #: _____

You must attach a copy of the front and back of your insurance card to this form.
Copying facilities will not be available at registration

Please check: _____ This citizen is not currently insured.