



**American Legion Auxiliary**

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**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, 2009**. 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. "01/01/09"

**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 14, 2009** to **June 20, 2009**. \_\_\_\_\_

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 \_\_\_\_\_

Has the Delegate named on the front had any of the following : ( √ if yes)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Medical Illness(es) | <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Mental Illness(es) |
| <input type="checkbox"/> Emotional Problems  | <input type="checkbox"/> Drug Abuse            | <input type="checkbox"/> Alcohol Use/Abuse  |

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

List all 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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