AMERICAN LEGION AUXILIARY
BUCKEYE GIRLS STATE

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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, 2004**. 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. "01/01/04"

SECTION 2 – Parent or Guardian Insurance Information (Attach 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 ______________

SECTION 3 – Parent or Guardian Consent for Emergency Treatment

********THIS SECTION MUST BE SIGNED BY PARENT/GUARDIAN TO ENSURE DELEGATE'S PARTICIPATION******

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 13, 2004** to **June 19, 2004**. ______________________________
Signature of Parent/Guardian

SECTION 4 – Physician and Medical Information

If a physical has been completed within the last six months 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)

? Medical Illness(es) ? Physical Disabilities ? Mental Illness(es)

? Emotional Problems ? Drug Abuse ? Alcohol Use/Abuse

If yes, explain ____

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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.

Signed ____ MD, DO or Parent

SECTION 5 – For BGS Medical Staff Use Only After Arrival

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