

American Legion Auxiliary Kentucky Girls State Medical History and Treatment Consent Form

Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Parent/Guardian Name(s) _____ Contact Number _____
Emergency Contact _____ Relationship _____ Contact Number _____

It is the goal of ALA KGS that every attendee 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 an attendee from certain activities, only to provide appropriate treatment in a time of medical need. Answers to these questions will be shared only with KGS counselors and staff as deemed necessary by the Director. MUST BE COMPLETED NO MORE THAN 14 DAYS PRIOR TO THE BEGINNING OF THE SESSION!

Circle all that apply with DATE and EXPLANATION:

ACL / MCL Injury: Surgery (Y / N) Date: _____	Diabetes (Insulin Dependent/Non-Insulin Dependent)	Measles
Brace needed (Y / N) When? _____	Dizziness / Lightheadedness / Fainting	Migraines
ADD/ADHD	Crohns Disease / Ulcerative Colitis	Mononucleosis
Anorexia / Bulimia	Chronic Headaches/Migraines	Mumps
Anxiety / Panic Attacks	Head Injury / Seizure Disorder	Severe Menstrual Cramps / PCOS
Asthma: (Mild / Moderate / Severe):	Heart Murmur or Abnormality	Scoliosis
Environmental / Exercise Induced	Hepatitis (A/B/C) or liver abnormality	Skin Disorder
Cancer	Homesickness	Sickle Cell Anemia
Chicken Pox / Shingles	Hypertension	Systemic Lupus Erythematosus
Covid	Hypoglycemia (low blood sugar)	Thyroid Disorder
Cystic Fibrosis	Kidney Stones	Vision Impairment / Corrective Lens
Depression		

Conditions or physical limitations not previously mentioned:

Allergies (drug, food, environmental):

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

*** Do you require and carry an EpiPen / Epinephrine Auto-Injector? (Y / N) ***

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

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

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

IF YOU CONSENT TO YOUR CHILD SELF ADMINISTERING ANY MEDICATION THEY BRING WITH THEM FOR THE TREATMENT OF ANY OF THE ABOVE LISTED CONDITIONS YOU MUST INITIAL HERE: _____

Surgical History (include date): _____

Primary Care Provider Name: _____ Phone Number: _____

Consent for Treatment

I, _____, parent/legal guardian of _____ certify this attendee is in good physical condition and give permission for her to receive any and all emergency treatment deemed necessary by medical personnel during ALA KGS in case of accident or illness, including transport to a local medical facility. I also grant permission for minor treatment and/or administration of over the counter medications (e.g. Tylenol, antacids, throat lozenges) by the ALA KGS Staff.

Parent/Guardian Signature: _____ Date: _____

Insurance Information

Policy Holder Name: _____ Employer: _____

Insurance Provider (Company): _____

Plan #: _____ Group #: _____ Policy #: _____

Please attach a copy of the front/back of your insurance card to this form. You will NOT have access to copier at registration.

Check here if not insured