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

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