KENTUCKY AMERICAN LEGION AUXILIARY GIRLS STATE
MEDICAL CERTIFICATE

HEALTH HISTORY: To be completed by parent or guardian and presented with the registration to Girls State. **Receipt of this form is mandatory.**

NAME_____DATE OF BIRTH_____

ADDRESS_____

PARENT/GUARDIAN_____

Phone Home _____Work _____Cell _____

PHYSICIAN'S NAME _____Phone _____

PAST ILLNESSES (Please check)

☐ Dizziness	☐ Polio	☐ Mumps
☐ Fainting	☐ Scarlet Fever	☐ Typhoid Fever
☐ Convulsions	☐ Diphtheria	☐ Hepatitis Type
☐ Measles	☐ Small Pox	☐ Migraines/Headaches
☐ Chicken Pox	☐ Mononucleosis	

☐ Ear, Nose, and Throat Problems – Describe: _____

Illnesses, injuries or hospitalizations within the past 30 days:

_____

Injuries to: ☐ Ankle ☐ Knee Joint Type_____

Does she wear ☐ Glasses ☐ Contact Lenses ☐ Dental appliances

FOOD ALLERGIES: _____ ALLERGIES_____

In case emergency medical service by a doctor is required and neither parent nor guardian can be contacted, do you hereby consent for the above names girl to be given necessary medical care as needed by the doctor selected by Girls State? ☐ YES ☐ NO

Signature of Parent/Guardian_____ Date_____

In the event that emergency medical service is necessary, please complete the following:

INSURANCE INFORMATION
Medical Insurance Provider Name_____
Provider Mailing Address_____
Policy Identification Number_____
Person to whom policy was issued _____

Please attach a copy of the front and back of your insurance card with this form if insured.

Revised 1/26/2012