American Legion Auxiliary • Department of North Dakota

Flickertail Girls State, Inc.

2017 Medical Form

Parent/Guardian must complete and sign this form.

No girl will be accepted without the **Medical Form** completely filled out and signed by the Parent/Guardian, and the **Physical Form** completely filled out and signed by the physician giving the physical.

Name of Applicant: _____

Address: _____

City, State, Zip Code _____

Date of birth: _____

In the event I cannot be reached, I hereby give permission to the physician selected by the American Legion Auxiliary Girls State Board to hospitalize, secure proper treatment and to order injections, anesthesia, or surgery for my child as named above at my expense.

Signature of Parent/Guardian: _____

Date: _____

Phone Number: _____

Address: _____

City, State, Zip Code: _____

Insurance Company: _____

Policy Number: _____

Insurance Co. Address: _____

_____

--See Physical Form on Page Two--

American Legion Auxiliary • Department of North Dakota

Flickertail Girls State, Inc.

2017 Physical Form

Physicians must complete and sign this form.

No girl will be accepted without the **Medical Form** completely filled out and signed by the Parent/Guardian, and the **Physical Form** completely filled out and signed by the physician giving the physical. Sports Physicals will be accepted. Attach a copy.

ALA Girls State by nature is strenuous, both physically and emotionally: therefore, ability to cope adequately with these conditions should be seriously considered when filling out this application.

Please indicate any presence the following, either currently or in the past:

☐ Diabetes	☐ Epilepsy	☐ Asthma	☐ Ulcer
☐ Hepatitis	☐ Spastic colon	☐ Allergy	☐ Heart trouble
☐ Lung trouble	☐ Skin rash	☐ Sore throat	☐ Athlete's foot
☐ Vision difficulty	☐ Drug problem	☐ Ear or sinus trouble	☐ Mental health concern

Other (please list): _____

If other conditions are listed, please explain: _____

Vaccination Dates:

Rubeola: _____ Rubella: _____ Tetanus Shot: _____

Recommendations & Restrictions: _____

Special Medications (Please list): _____

Can medications be self-administered? (Check one) ☐ Yes ☐ No

If no please explain: _____

I certify that I have examined the above named applicant and find she is in good condition and has no contagious or infectious disease symptoms on this date.

Physician's Signature: _____ Date: _____

Phone Number: _____