Return this form **no later than April 28, 2017** to the address on the cover page of these forms.

ALA CORNHUSKER GIRLS STATE
CONSENT FOR MEDICAL TREATMENT

_____, age _____, will be
(Print full name of minor)

Attending ALA Cornhusker Girls State on the University of Nebraska-Lincoln campus on June 4 – 10, 2017, and I, _____ grant permission to the medical
(Print Full Name of Parent or Guardian)

staff of Cornhusker Girls State to act on my behalf for said minor in granting permission for evaluation and/or treatment of minor medical problems.

I UNDERSTAND THAT SHOULD A MAJOR MEDICAL PROBLEM ARISE, AN ATTEMPT WILL BE MADE TO NOTIFY ME BY TELEPHONE. IN THE EVENT THAT I CANNOT BE REACHED, I HEREBY GIVE MY CONSENT TO SUCH MEDICAL TREATMENT AS DEEMED NECESSARY, INCLUDING X-RAY EXAMINATIONS AND ANESTHESIA, TO BE RENDERED TO THE ABOVE NAMED MINOR, BY A LICENSED PHYSICIAN OR PHYSICIANS. I UNDERSTAND THAT CHARGES FOR SERVICES ARE THE RESPONSIBILITY OF THE PATIENT AND/OR PARENT/GUARDIAN.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION.

_____ _____
(Signature of parent or guardian) (Date Signed)

TELEPHONE: Home: _____ Work: _____ Cell: _____

INSURANCE INFORMATION:

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy/Identification Number(s): _____

The medical information you are providing will only be seen by the office and medical staff of Cornhusker Girls State. It will not be shared with anyone. We use this information to help care for your daughter while she is here with us. It helps us to know if there are issues we need to watch for.

Past Illnesses (✓)

_____ Measles	**_____ Tetanus**	**_____Tuberculosis**
_____ Mumps	**_____ Mononucleosis**	**_____ Hepatitis, If Yes, Type ___**
_____ Chicken Pox	**_____ Strep Throat**	**_____ Organ Transplant**
_____ Whooping Cough	**_____ Pneumonia**	**_____ Heat Exhaustion**

Present State of Health (✓)

_____ Diabetes	**_____ Ulcers**	**_____ Ear/Nose/Throat Problems**
_____ Epilepsy	**_____ Heart Condition**	**_____ Appendicitis**
_____ Asthma	**_____ Vision Impairment**	**_____ Urinary Tract Infections**
_____ Drug problems	**_____ Hearing impairment**	**_____ Bleeding Issues**

HEAD	**✓ YES**	**✓ NO**
Do you have headaches? What helps?		
Do you suffer from dizziness?		
Do you have any sinus problems?		
Do you suffer from a seizure disorder? Do you take any medication for this?		
Do you wear contacts or glasses?		
Do you have hearing problems?		
Have you had a head injury in the past?		
Do you have any Ear/Nose/Throat problems?		
CHEST		
Do you have asthma? How is it controlled?		
Do you have shortness of breath?		
Do you have any heart conditions such as murmur, high or low blood pressure, palpitations, or chest pain?		
ABDOMEN		
Do you have occasional diarrhea?		
Do you have occasional constipation?		
Do you have occasional nausea or vomiting?		
Do you have heartburn or indigestion?		
Do you have any food intolerances or allergies?		
MUSCULOSKELETAL		
Do you have any knee issues? Past surgeries?		
Do you have any ankle issues? Past surgeries?		
Do you have joint pain?		
Do you have back pain?		
Do you wear any braces or prosthesis?		
FEMALE		
Do you have menstrual cramps? What helps?		
Have you ever had a urinary tract infection?		
MENTAL/EMOTIONAL		
Do you suffer from anxiety?		
Do you have sleep problems?		
Do you have panic attacks?		
Are you depressed?		
Are there any recent mood changes we should know about?		
Do you have Autism, Asperger's Syndrome, ADHA or other issues we should know about?		

Current medications, dosage, frequency, & storage _____

_____

Allergies ***(include food, drug, or environmental)*** _____

_____

DATE OF LAST TETANUS VACINATION _____