Return this form **no later than April 27, 2018** to the address on the cover page of these forms.

**AMERICAN LEGION AUXILIARY “CORNHUSKER” GIRLS STATE**

**CONSENT FOR MEDICAL TREATMENT - 2018**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** age \_\_\_\_\_\_\_\_,will be

 (Print full name of minor)

Attending ALA Cornhusker Girls State on the University of Nebraska-Lincoln campus on June 3 - 9, 2018, 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**