Please complete and return form by May 1, 2026, to
ALA Cornhusker Girls State
150 NW 40th Street Unit B
Lincoln NE 68528

CONSENT TO MEDICAL TREATMENT AND HOSPITAL SERVICES

This will certify that we (I), the undersigned parent(s) or guardian(s) of ____ do, in the event that our (my) daughter becomes a participating member of the American Legion Auxiliary Girls State, to be held on the University of Nebraska-Lincoln campus May 31 – June 6, 2026, hereby consent and grant permission, should the necessity of medical care arise, to the furnishing of medical treatment and hospital services as ordered or recommended by a qualified attending physician, including the administration of an anesthetic, laboratory procedures, medical or surgical treatment, X-ray examination, or other hospital services. Permission is also granted for minor treatment, including the use of emergency first aid medications by the ALA Girls State staff or nurses.

American Legion Auxiliary Girls State Citizen Information (please print):

Name: ____

Date of birth: _______/_______/__________ (mm/dd/yyyy)

Parent/Guardian phone, home: (______)__________________________________

Work: (______)______________________ Cell: (______)____________________

Please attach a copy of the front and back of your insurance card

____ ____________________

Signature of Parent/Guardian Date

____ ____________________

Signature of Parent/Guardian Date

Medical Information

Name: ____

Parent/Guardian Name: ____

Parent/Guardian Phone: Home: ________________________ Cell: ______________________

Physician Name and Phone: ____

MEDICAL HISTORY

Have you ever had or do you have any of the following medical problems?

	YES	NO		YES	NO
Allergies	____	____	Stomach Problems	____	____
Diabetes	____	____	Back Pain or Injury	____	____
Ashma	____	____	Joint Pain or Injury	____	____
Severe Headaches	____	____	Hepatitis	____	____
Seizures	____	____	Drug Problems	____	____
Depression	____	____	Dizziness	____	____
Broken Bones	____	____	Visual Problems	____	____
High Blood Pressure	____	____	Ear, Nose, Throat Problems	____	____
Heart Problems	____	____	Eating Disorders	____	____
Other	____	____			

Explain all “YES” answers:

Are you currently under a doctor’s care? If so, for what?

Are you taking any prescription medications? If so, list drug, dosage, and frequency.

Are you taking over the counter medications? If so, list drug, dosage, frequency and for what reason.

Please list any surgeries you have had and what year.

Are there any major illnesses in the family?

Date of last physical ___________________________

I hereby certify that all the above information is true to the best of my knowledge.

Parent/Guardian Signature:____Date:_____________