



AMERICAN LEGION AUXILIARY



American Legion Auxiliary • Department of North Dakota  
*Flickertail Girls State, Inc.*

**Medical Form**

Parent/Guardian must fill in and sign this card.

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 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



American Legion Auxiliary • Department of North Dakota  
*Flickertail Girls State, Inc.*

**Physical Form**

Physicians must fill in and sign this card.

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.**

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.

**Is there any presence of:**

- |  |   |                                       |   |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Ulcer          |
| <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Spastic Colon            | <input type="checkbox"/> Allergy      | <input type="checkbox"/> Heart Trouble  |
| <input type="checkbox"/> Lung Trouble      | <input type="checkbox"/> Skin Rash                | <input type="checkbox"/> Sore Throat  | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Vision Difficulty | <input type="checkbox"/> Ear or Sinus Trouble     | <input type="checkbox"/> Drug Problem |   |
| <input type="checkbox"/> Emotional Problem | <input type="checkbox"/> Former Emotional Problem |                                       |   |

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?                      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: \_\_\_\_\_