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: ______________________________

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--See Physical Form on Page Two--

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:

____ Diabetes
____ Epilepsy
____ Asthma
____ Ulcer
____ Hepatitis
____ Spastic Colon
____ Allergy
____ Heart Trouble
____ Lung Trouble
____ Skin Rash
____ Sore Throat
____ Athlete's Foot
____ Vision Difficulty
____ Ear or Sinus Trouble
____ Drug Problem
____ Emotional Problem
____ 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: ______________________