

The American Legion Boys State of Kansas

Medical Form (page 1 of 2 pages)

NO DELEGATE WILL BE ADMITTED WITHOUT THIS FORM—BE SURE TO BRING IT WITH YOU

GENERAL INFORMATION ABOUT THE DELEGATE

Name _____ [Office Use Only – Ctrl _____ Hall _____ RM _____]

Address _____ High School _____

City, State, Zip _____

Age _____ Birth date _____

Has the delegate ever had: Measles _____ Mumps _____ Chicken Pox _____ Small Pox _____ Diphtheria _____

Scarlet Fever _____ Infantile Paralysis _____ Heart Trouble _____ Ear or Sinus Trouble _____

Has the delegate been exposed to any contagious diseases within the last three weeks? _____

Delegate's insurance company _____ Policy Number _____
(Note: it would be most helpful to attach a copy of your insurance card to this form)

Note: Please furnish insurance information, if any. If none, enter "None."

MEDICAL AUTHORIZATION: In the event of treatment by Mercy Health Center (hereinafter "Medical Center"), Manhattan, Kansas, we hereby authorize and request the Medical Center and the physicians who attend delegate while a patient in said hospital during the Kansas Boys State session in June, 20__ to furnish to (name of family physician) _____ pertinent information concerning delegate's case history and treatment and examination which delegate received, including copies of hospital and medical records, x-rays, etc.

We hereby authorize the Executive Director or Associate Director(s) of the American Legion Boys State of Kansas, or any of their designated representatives, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment of hospital care to be rendered to the delegate if necessary and when efforts to contact me are unsuccessful.

We further consent to the examination of the minor child by a duly licensed physician without contacting me for the purpose of ascertaining whether or not any treatment or care may be required, and what, if any, activities or limitations thereon, may be appropriate for my child during the American Legion Boys State of Kansas.

INSURANCE: We hereby state that the delegate is covered by medical insurance listed herein (if any). We understand and agree that said insurance (if any) will be primary insurance for the delegate while a participant at Boys State. We agree to cooperate fully with the staff of Boys State and the insurance company which provides the secondary medical insurance coverage for Boys State by providing information, assistance in filing claims with our insurance company, and in any other manner to assist so that the cost of any medical care rendered for injury or illness will be promptly paid to the supplier of medical care for the delegate.

CUSTODIAN OR GUARDIAN STATEMENT

I hereby state that I am a natural parent or legal guardian having custody of _____, a minor child, age _____, born on _____, 19____, who resides with me at _____

and that I have read the above authorizations and hereby consent and agree to such release and authorization.

Date _____ Signature of Parent or Guardian _____

Date _____ Signature of Delegate _____

CUSTODIAN OR GUARDIAN CONTACT INFORMATION

Home Phone (____) _____ - _____ Notes: _____

Work Phone (____) _____ - _____ Notes: _____

Cell Phone (____) _____ - _____ Notes: _____

Other Phone (____) _____ - _____ Notes: _____

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Medical Form (page 2 of 2 pages)

NOTE: A KSHSAA physical form (or the equivalent if you don't attend a school in Kansas) for the 2016-17 school year MAY be substituted for this page provided that any new restrictions accompany the form.

MEDICAL HISTORY

Recent hospitalizations or surgeries: YES NO

If YES, explain:

Current medical procedures/therapies: YES NO

If YES, please list:

Current medications:

Name Dose Frequency

Name Dose Frequency

Name Dose Frequency

Name Dose Frequency

Allergies: Seasonal Food Allergies Medication Allergies

Blank lines for allergy details

PHYSICAL EXAMINATION

NOTE TO EXAMINER: Please consider Boys State's desire to eliminate as far as possible communicable disease, and the ability to engage in a 7-day activity program.

HEENT:

CV:

NEURO:

MUSCULOSKELETAL:

GU:

GI:

INTEG:

May participate in sports or other physical activities: YES NO

Physical Limitations or Special Needs:

Blank line for physical limitations or special needs

Physician's Name Signature

Address Phone