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 _____

COVID-19_____ 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 Ascension Via Christi Hospital (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 re 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 ascertaining whether 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 _____, _____, 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: _____

The American Legion Boys State of Kansas

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 2021-2022 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 (please list) ____ Medication Allergies (please list)

_____

_____

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: _____

_____

Physician's Name _____ Signature _____

Address _____ Phone (_____) _____--_____

_____

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