DEPARTMENT OF ARIZONA AMERICAN LEGION AUXILIARY GIRLS STATE_____ ☐

MEDICAL CERTIFICATE

HEALTH HISTORY: To be completed by parent or guardian and presented at time of registration to GIRLS STATE.
NAME _____DATE OF BIRTH_____
ADDRESS_____
PARENT/GUARDIAN HOME PHONE NUMBER_____
PARENT CELL NUMBER_____WORK NUMBER_____
PHYSICIAN'S NAME_____PHYSICIAN'S NUMBER_____

PAST ILLNESSES (please check)

		_____Glasses	_____Contact lenses
_____Measles	_____Small Pox	_____Poliomyelitis	_____Migraines/Headaches
_____Mumps	_____Diphtheria	_____Typhoid Fever	_____Knee
_____Chicken Pox	_____Scarlet Fever	_____Hepatitis if yes, type _____	

_____Mononucleosis _____Ear, Nose, Throat problems, if yes, describe_____
_____Surgery if yes, type_____
_____Recent illnesses, injuries or hospitalizations? If yes,_____
_____Dizziness, fainting, convulsions _____Dental appliances_____ Ankle_____ Joint injuries if yes,_____
FOOD ALLERGIES_____ALLERGIES_____

During Girls State if treatment is required for minor illness or injury, it may be rendered by staff nurse. In case emergency medical service by a doctor is required and neither parent or guardian can be contacted, do you hereby consent for above named girl to be given necessary medical care as needed by the doctor selected by Girls State? **YES_____NO_____**
Also I give permission to the staff nurse to administer any over the counter medication deemed necessary such as TYLENOL, MYLANTA, TUMS, PEPTO BISMOL, BENADRYL, ROBITUSSIN, COUGH DROPS, IBUPROFEN, MIDOL, SORE THROAT SPRAY, ALLERGY TABLETS, ANTI ITCH CREAM, ANTIBOITIC OINTMENT, PEROXIDE, RUBBING ALCHOL.
Signature of Parent or guardian_____

TO BE COMPLETED AND SIGNED BY A MEDICAL PROVIDER within 3 weeks prior to leaving for Girls State.

Present State of Health (yes or no) ***(Current)***

_____Diabetes	_____Ulcer	_____ENT problems	_____Epilepsy	_____*Throat*
_____Heart Condition	_____Asthma	_____Drug Problems	_____Skin	_____*BP*
_____Vision Impairment	_____Lungs	_____Emotional Problems		_____*Pulse*

_____ Immunizations Current _____Date of last Tetanus _____COVID Immunizations
Current medications, dosages, frequency_____
_____
_____
_____
Does she have any physical restriction?_____
(glasses, contacts, prostheses, etc.)
I certify that I have examined this person and she is in good physical condition. There are no health restrictions that would inhibit and/or prohibit her participation in the program.

_____Date of Exam_____
Signature of Examining Medical Provider

INSURANCE INFORMATION (IF INSURED)
Medical Insurance Provider Name:_____
Provider Mailing Address:_____
Policy Identification number:_____
Person to whom policy was issued:_____
PLEASE ATTACH COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD, (if insured) WITH THIS FORM.
Emergency contact if necessary _____Phone_____

5/2026