To be filled in by ALA Department
Last name _____ Counselor _____ Dorm _____ Room # _____

Medical Certificate
American Legion Auxiliary
Colorado Girls State

To be filled out by applicant

Name _____
Last First Middle initial

Address _____
Street City Zip

Do you have problems with any of the following? (Check all that apply)

Eyes___ Ears ___ Asthma ___ Diabetes ___ Hay fever ___ Allergies ___ Other ___

If you answered yes to any of the above, explain here: _____

_____

If you are currently taking any medications, state name, dosage, and method of administration

_____

Date of last DPT/DT booster _____ Date of last MMR booster _____

Please note any physical limitations or special requirements: _____

_____

<u>Parent or Guardian Consent</u>

In consideration of the instructions and training to be given my daughter at ALA Colorado Girls State, I do hereby release and discharge the American Legion Auxiliary, Department of Colorado, ALA Colorado Girls State, its officers, agents, instructors, and employees from all claims, demands, damages, suits, actions, or causes of action which I may, can or shall have by reason of any illness, injury, or accident incurred, or suffered by my said daughter while in attendance, or in connection with travel to and from the activities of the above organization, no matter how caused or occasioned.

I authorize necessary and appropriate medical treatment.
Insurance Company: _____

Group Name/Number: _____ Policy Number: _____

I have read and agree to the above consent this _____ day of _____, 20 _____

_____ _____
Parent or Guardian signature (s) home phone #

_____ _____
Work phone # Mother Cell phone # Mother

_____ _____
Work phone # Father Cell phone # Father