Program: AMERICAN LEGION AUXILIARY – DEPARTMENT OF MICHIGAN – GIRLS STATE
Dates: SUNDAY, JUNE 18, 2016 – SATURDAY, JUNE 24, 2017

AUTHORIZATION FOR PURPOSES OF PROVIDING MEDICAL TREATMENT
MICHIGAN STATE UNIVERSITY

Your daughter will be attending the American Legion Auxiliary, Department of Michigan, Girls State program to be held at Michigan State University on the above date(s). We are asking you to complete this form to give an appropriate medical facility permission to treat her for minor injury or medical problems. In the event of serious injury or illness, you will be contacted; treatment will proceed before contacting you only if the situation is urgent and does not permit delay. **Please make sure it is legible!**

Child's Name _____ Date of Birth _____

Address _____ Name of Primary Care Physician _____

_____ Address _____

Phone _____ Phone _____

INFORMATION NEEDED ABOUT CHILD:	YES	NO	IF YES - INDICATE OR LIST BELOW
Is there any chronic problem or illness?	____	____	_____
Has the person been treated recently for some medical problem?	____	____	_____
Are there any allergies to medications or local anesthesia?	____	____	_____

List any medications now being taken for treatment of any medical problem _____

Date of last Tetanus Shot: _____

HEALTH INSURANCE INFORMATION:

Policyholder's Name and Relationship to Patient _____

Policyholder's Address _____

Name and Address of Insurance Co. _____

If you have HMO or PHP insurance - list the emergency treatment authorization phone number _____

Name and Address of Employer _____

All Policy Numbers (please identify) _____

I, _____, as parent/legal guardian of _____ do hereby

Authorize BERYL ROBBINS AND/OR RYSTA BROWN to seek any medical and/or surgical treatment necessary for the care of my child.

The above-designated Program Directors are hereby authorized to incur medical costs necessary to provide medical treatment for said child, for which I shall be fully responsible. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature _____ Relationship to Child _____

Daytime/Work EMERGENCY PHONE NUMBER _____

Address _____