

AMERICAN LEGION & AMERICAN LEGION AUXILIARY
NM STATERS
Medical Form

For Office Use Only
Assigned City:

Email copy to alanmgirlsstate@gmail.com by May 25 and bring original to check-in.

NAME _____ DOB _____

PARENT/GUARDIAN _____

STREET ADDRESS _____

CITY, STATE & ZIP CODE _____

HOME PHONE _____ PARENT/ GUARDIAN CELL PHONE _____

EMERGENCY CONTACT _____ PHONE _____

EMERGENCY CONTACT RELATIONSHIP _____

PHYSICIAN _____ PHONE _____

DO YOU CONSIDER YOURSELF IN GOOD PHYSICAL HEALTH? YES NO

PRESENT STATE OF HEALTH (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Asthma or Other Respiratory Conditions | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stomach Problems |

ARE YOUR IMMUNIZATIONS UP TO DATE? YES NO

HAVE YOU BEEN EXPOSED TO ANY INFECTIOUS DISEASES IN THE PAST TWO (2) WEEKS? YES NO

DO YOU PLAN TO TRAVEL INTERNATIONALLY WITHIN TWO (2) WEEKS OF SESSION? YES NO

IF YES, PLEASE LIST _____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS (EVEN IF JUST OCCASIONAL USE)? YES NO

IF YES, PLEASE LIST MEDICATION, DOSE AND FREQUENCY _____

DO YOU HAVE ANY ALLERGIES TO FOOD, MEDICATIONS OR ENVIRONMENTAL ITEMS? YES NO

IF YES, PLEASE LIST ALL ALLERGIES _____

DO YOU HAVE ANY PHYSICAL LIMITATIONS AND/OR NEED ANY SPECIAL ACCOMMODATIONS? YES NO

IF YES, PLEASE LIST _____

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PLEASE LIST ANY FOOD CONSIDERATIONS/ DIETARY RESTRICTIONS WE SHOULD BE AWARE OF
(VEGETARIAN, GLUTEN FREE, ETC) _____

PLEASE LIST ANY CURRENT MEDICAL CONDITIONS WE SHOULD BE AWARE OF _____

THIS IS A WEEK OF ACTIVITY, IS YOUR CHILD PHYSICALLY ABLE TO PARTICIPATE IN THIS TYPE OF ACTIVITY? YES NO

I GIVE PERMISSION FOR MY CHILD TO BE ISSUED OVER THE COUNTER MEDICATION AS NEEDED BY THE NURSE. YES NO

IF YOU SHOULD BECOME ILL YOUR PARENTS WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED.

Name of insurance company _____

PLEASE SEND A COPY OF BOTH SIDES OF YOUR INSURANCE CARD WHEN RETURNING THIS FORM, IF AVAILABLE.

I give permission for my child to be treated in case of illness or injury while attending the American Legion & American Legion Auxiliary New Mexico Staters program.

Signature of Parent/Guardian _____ Date _____

Signature of NM Stater Attendee _____ Date _____

Notarized _____

Date _____

Expiration date _____

BE SURE THIS FORM IS NOTARIZED!

