AMERICAN LEGION AUXILIARY BADGER Girls STATE

Consent for Medication Administration and Medical Treatment
University of Wisconsin - Oshkosh

To the Parents(s) or Legal Guardian:

If your daughter or ward will be under the age of 18 while at the University of Wisconsin-Oshkosh, it is American Legion Auxiliary Badger Girls State policy to secure your consent for medication distribution and for the use of medical devices.

Place any prescription drugs or medications in a zip lock bag identified with your name. Bring only the amount you'll need for the amount of days at ALABGS session. They are to be in the original container, the name of the medication, the dosage, the frequency of administration and the route of administration should be indicated on the label. The label should also have the name of the prescribing physician, the prescription number, date prescribed, possible adverse reaction, the specific conditions when contact should be made with the physician and other special instructions as needed.
All medications brought by a citizen who is under 18 years of age shall be kept in a locked unit and shall be administered by one of our Nursing staff. A citizen may carry bee sting medications, inhalers, an insulin syringe or other medication or device used in the event of life threatening situations. Any deviation from this will be up to the Head Nurse.

_____ No medication has been brought to American Legion Auxiliary Badger Girls State.

_____ I agree to have the medication or medical device administered by the American Legion Auxiliary Badger Girls State Health Staff. However, a limited amount of medication for life threatening conditions may be carried by my daughter/ward. (i.e. bee sting kits, inhalers)

_____	_____	_____
Name of Medication(s)	Prescribing Doctor	Doctor Phone No.
_____	_____	_____
Amount to be taken	How is it taken?	When to be administered
_____	_____	
Day(s) to be taken	Special instructions	

- If your daughter or ward will be under the age of 18 years while at American Legion Auxiliary Badger Girls State, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury. (Mercy Medical Center or Aurora Medical Group)
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System and the University of Wisconsin-Oshkosh, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the American Legion Auxiliary Badger Girls State session.

Date_____ Name of Student/ALABGS Delegate _____
(please print)

Signature of Parent or Guardian _____

Parent/Guardian MUST sign.

Completed medical forms should be submitted as soon as possible as an email attachment and sent to alabgs.reg@gmail.com.

PART TWO: CONFIDENTIAL HEALTH HISTORY

Full Participant Name:

American Legion Auxiliary Badger Girls State
Session Dates: June 17-22, 2018

Full Home Address:

City: State: Zip:

Primary phone #:

Secondary phone #:

Date of Birth: _____ /_____ /_____

Height: Weight:

Parent/Guardian Name:

Relationship:

Address (if different than above):

City: State: Zip:

Work phone #:

Does participant have allergic reactions to:

☐ Yes ☐ No Penicillin
☐ Yes ☐ No Other Antibiotics _____
☐ Yes ☐ No Other Medicine (type) _____
☐ Yes ☐ No Insect Bites/Stings_____

Alternate contacts (in the event that the Parent/Guardian cannot be contacted during an injury or illness)

Name: Relationship:

Address: City: State: Zip:

Phone #:

Alternate contact #2

Name: Relationship:

Address: City: State: Zip:

Phone #:

Does participant take medication on a regular basis? ☐ Yes ☐ No

If Yes, Identify_____
(consent for medication administration must be signed on reverse)

Has participant had or presently experiencing:

☐ Yes ☐ No Allergies	☐ Yes ☐ No Asthma	☐ Yes ☐ No Bleeding Disorder	☐ Yes ☐ No Cancer
☐ Yes ☐ No Colitis	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Epilepsy/Seizures/ Blackouts	☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Hernia	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Joint Injury/Surgery	☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Menstrual Difficulties	☐ Yes ☐ No Mental/Emotional Problems	☐ Yes ☐ No Neck/Back Pain/Injury	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Ulcer		

Other:

Physician:_____ Telephone:_____

Policyholder's Name:_____ Group No:_____

Insurance Co:_____ Subscriber or Policy No:_____

Immunization Record

*MMR (measles, mumps, rubella)
Dose 1-Immunization at age 1 ☐ Yes ☐ No
Dose 2 ☐ Yes ☐ No

***Tetanus-Diphtheria**
☐ **Yes** ☐ **No** ***Year of last Tetanus boost (must be within last 10 years) ____/____/_____**

Has participant ever had major surgery or been hospitalized? ☐ Yes ☐ No

Please explain any significant operations, accidents or illnesses, and last medical attention and reason:

Does the participant have any physical condition(s) requiring special considerations? Explain.

A physical examination within 24 months of the session is recommended.

Date of participant's last physical examination:_____

Notes:

PARENT OR GUARDIAN SIGNATURE_____ **DATE**_____