May 2025

INFORMATION FOR PHYSICIANS, NURSE PRACTITIONER OR OTHER MEDICAL PROVIDER OF DELEGATES TO AMERICAN LEGION AUXILIARY GIRLS STATE

Your patient has been selected to attend American Legion Auxiliary Arizona Girls State on the campus of University of Arizona, in Tucson, Arizona, June 1-8, 2025 We would like to stress that this is a 8 day session which is physically, mentally and emotionally strenuous. The program is structured as a very intense learning situation and involves walking from the dorm to classrooms and around the campus during the day and night.

The American Legion Auxiliary has registered nurses on staff 24 hours a day during our entire session. If your patient develops a problem, which our medical personnel feel deserves the attention of a physician; she will be taken to the emergency room at Banner University Medical Center, St. Mary's Hospital or Tucson Medical Center. We have experienced excellent cooperation with these hospitals, and they have been very helpful to our American Legion Auxiliary Arizona Girls State Staff, the parents/guardians, and physicians of our Girls State citizens.

Please complete the American Legion Auxiliary Arizona Girls State medical form, which your patient has given you and attach an additional sheet if there is any further information that you feel would be helpful. **This is not a complete physical. It is a well checkup to make sure patient is okay to attend the program.** This is why insurance wants the checkup done within 4 weeks of the program.

We request that you advise our medical personnel of any past serious conditions or problems, so we can give your patient any special care she may need. For instance, has the patient ever had rheumatic fever, a problem with nosebleeds or fainting, nervous conditions, etc. Our medical personnel need pertinent information in case treatment is required during her stay at Girls State.

If your patient should become ill or have any problem immediately before attending Girls State from June 1-8, 2025, we would appreciate a release from you stating she is able to maintain the schedule at Girls State. Included in the release, please give us your orders for treatment she should receive for her condition, as well as any trouble signs to watch for.

We appreciate your cooperation and thank you for your assistance. Please be assured that all information is kept strictly confidential and in compliance with HIPPA guidelines for camps and is shredded after 3 years.

Penny Maklary…Director

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 4 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.

Other Emergency Contact _____Phone_____

5/2025