

LOUISIANA BOYS STATE CITIZEN MEDICAL CERTIFICATE

American Legion Boys State
Medical Consent/Waiver Page 1 of 2
Revised 1/14/2013

Name \_\_\_\_\_ District \_\_\_\_\_

This form must be complete in full NOT MORE THAN 90 DAYS prior to the beginning of Boys State. Any citizen who arrives without a completed Medical certificate will not be allowed to participate in the program until the completed form is submitted. Boys State by nature is strenuous, both physically and emotionally; therefore, the ability to cope adequately with these conditions should be seriously considered when completing this statement. Parent signature must be witnessed by Post Commander, Procurement Chairperson, School Principal or Counselor.

TO BE COMPLETED BY PARENT/GUARDIAN: Please print or type.

Boys State Citizen's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Father/Guardian's Name: Mother/Guardian's Name: \_\_\_\_\_

Mother/Guardian's Home Phone: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Work: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Cell: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ]

Father/Guardian's Home Phone: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Work: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Cell: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ]

Parent/Guardian Home email: \_\_\_\_\_ Work email: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's phone: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ]

In Case of Emergency Alternate contact: \_\_\_\_\_ Work: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Cell: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ]

PAST ILLNESSES (Please check):

- \_\_\_ Measles \_\_\_ Small Pox \_\_\_ Poliomyelitis
\_\_\_ Mumps \_\_\_ Diphtheria \_\_\_ Typhoid Fever
\_\_\_ Chicken Pox \_\_\_ Scarlet Fever \_\_\_ Hepatitis - If yes, type \_\_\_\_\_
\_\_\_ Mononucleosis \_\_\_ Ear, Nose, Throat problems - If yes, describe \_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN: PRESENT STATE OF HEALTH (Please check all that applies)

- \_\_\_ Diabetes \_\_\_ Asthma \_\_\_ Heart Condition \_\_\_ Hearing Impairment \_\_\_ Emotional Problems
\_\_\_ Epilepsy \_\_\_ Ulcer \_\_\_ Vision Impairment \_\_\_ ENT Problems \_\_\_ Drug Problems

Other Physical Conditions or hearing impaired: \_\_\_\_\_

Current medications, dosage & frequency: \_\_\_\_\_

List medication requiring refrigeration: \_\_\_\_\_

Allergies: (Include drug, food, other): \_\_\_\_\_

Physical limitations (glasses, contacts, prostheses, etc): \_\_\_\_\_

Date of last Tetanus Vaccination: \_\_\_\_\_

I certify that I have examined this person and he is in good physical condition. There are no health restrictions that would inhibit his participation in this program.

Signature of Examining Physician: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

CONSENT TO MEDICAL TREATMENT AND HOSPITAL SERVICES

This will certify that I/we am/are the parent or legal guardians of \_\_\_\_\_ who is under the age of eighteen years. He is \_\_\_\_\_ years of age.

In the event that my/our son becomes a participant of the American Legion Louisiana Boys State, to be held in Natchitoches, Louisiana on the campus of Northwestern State University, I/we hereby consent and grant permission, should the necessity of medical care arise, to the furnishing of medical treatment and hospital services as ordered or recommended by a qualified attending physician, including the administration of an anesthetic, laboratory procedures, medical or surgical treatment, x-ray examination or other hospital services. Permission is also granted for minor treatment, including the use of First Aid medications and over the counter pharmaceuticals to be given by the Boys State Staff or Nurse.

INSURANCE INFORMATION

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 TO THIS FORM

## INFORMATION USE DISCLOSURE

In compliance with Health Insurance Portability Act of 1996 (HIPPA) and the Federal Privacy Act of 1974, the Louisiana American Legion Boys State recognizes that private information cannot be used or disclosed except as described. This includes such information or names, addresses, phone numbers, fax numbers, e-mail addresses, Social Security numbers and health information about staff members and youth program participants. The intended uses of the information collected for Boys State are described below.

### **Purposes**

1. To facilitate emergency health care, if needed, with prior permission of the parent/guardian.
2. To register and process lists and name tags for youth and staff at Boys State.
3. To facilitate housing lists for Boys State staff members and the Northwestern State University.
4. To provide a directory of Boys State staff members and citizens.

### **Access**

1. American Legion Even Planning staff, Boys State Chairman and Boys State Nurse.
2. Basic contact information via the directory to Boys State Staff and participants.

### **On Site Storage**

1. Information will be secured in locked cabinets and office spaces.

### **Retention of Records Policy**

1. All documents relating to Louisiana American Legion Boys State will be retained for a minimum of one (1) year from the date of creation or last in effect. After this period of time has lapsed, the Louisiana American Legion Staff will shred all of the documents and dispose of its property.

I have received and read the required Health Insurance Portability Act of 1996 (HIPPA) Notice of Privacy Practices as provided above. This notice includes procedures that will be taken to assure that all health-related information is kept confidential and protected.

## WAIVER AND CONSENT

There are many opportunities for pictures to be taken at the Louisiana American Legion Boys State program. This may include pictures taken by visiting press, staff, and/or citizens. Therefore I/we do give my permission for my/our son/guardian's picture or name to be used in regard to the Louisiana American Legion Boys State program.

I/we understand and confirm that participation in the American Legion Boys State program is voluntary and hereby consent and grant permission for my/our son/guardian to participate in all activities in conjunction with this program. I/we further understand that my son/guardian's participation may involve risk of injury and loss, both to person and to property. On behalf of my minor child/guardian, I/we assume all risks in any way connected with said participation and I/we accept personal responsibility for any liability, injury, loss, or damage in any way connected with said participation.

This will further certify that I/we, the undersigned, in consideration of the benefits and opportunities derived by my son/guardian who is a participant of the Louisiana American Legion Boys State program to be held at Northwestern State University in Natchitoches, Louisiana and having activities on the Northwestern State University Campus, do hereby release and discharge the American Legion, its officers, agents, staff and employees from any and all claims, demands, suits, actions, or course of action which may, can, or shall have reason of illness, injury or accident incurred or suffered by said son/guardian while in attendance of said American Legion Louisiana Boys State, and that the provision of such insurance is my/our own personal responsibility.

I/we do hereby certify that the information provided on pages one (1) and two (2) of this form is true and correct to the best of my/our knowledge.

\_\_\_\_\_  
Printed name of Boys State Citizen

\_\_\_\_\_  
Signature of Boys State Citizen

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Father/Guardian

\_\_\_\_\_  
Printed name of Mother/Guardian

\_\_\_\_\_  
Signature of Father/Guardian

\_\_\_\_\_  
Signature of Mother/Guardian

\_\_\_\_\_  
Witness: Printed name

\_\_\_\_\_  
Witness: Signature