American Legion Auxiliary
Florida Girls State
Physical History

This form is to be signed, notarized and submitted at online registration

Name _____ DOB: _____

Parent/Guardian _____

Street Address _____

City, Zip _____

Home Phone _____ Parent/Guardian Cell _____

Emergency Contact _____ Phone _____

2nd Emergency Contact _____Phone _____

Contact relationship _____

Physician _____ Phone _____

	YES	NO
Are your immunization up to date:	_____	_____
Do you have diabetes	_____	_____
Do you have asthma or any other respiratory conditions	_____	_____

Please list any menstrual problems _____

Have you ever fainted	_____	_____
Do you suffer from headaches or migraines	_____	_____
Do you have any current stomach problems	_____	_____
Do you consider yourself in good physical health	_____	_____
Do you have an anxiety disorder	_____	_____
Have you been exposed to any infectious diseases in the last two (2) weeks	_____	_____

Are you currently taking any prescription or over the counter medications, (even if just occasional use) If yes, please list medication, dose and frequency _____

_____

Do you have any allergies to food, medications or environmental items . _____ _____

If Yes, please list all allergies _____

_____

Do you have any physical limitations and/or need any special accommodations? ***(FL Girls State averages walking 6 miles per day. Girls State is an active program.)*** Will you be able to participate?_____

_____

Food Form should be completed for Vegetarians and Vegans

Please list any food considerations/dietary restrictions we should be aware of (vegetarian, gluten free, etc)
_____

_____

Please list any medical conditions we should be aware of _____

_____

I give permission for my daughter to be treated in case of illness or injury while attending American Legion Auxiliary Florida Girls State.

Name of insurance company _____ PLEASE SEND A **COPY OF BOTH SIDES** OF YOUR INSURANCE CARD WHEN SUBMITTING THIS FORM.

SHOULD DELEGATE BECOME ILL DURING GIRLS STATE, PARENTS WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED.

_____ My daughter **DOES NOT** have insurance coverage. My signature below is acknowledgement of my personal responsibility of any medical costs incurred. Florida State University or ALA Dept of FL Girls State is not responsible for any medical cost for my daughter

In witness of the undersigned parent/guardian of the above delegate _____ has executed this statement of voluntary consent on this _____ date of _____.

Sworn and subscribed before me this _____ date of _____.

_____ _____

Parent/Guardian Notary Public, State of Florida

Personally Known ____ Address: _____

Photo ID _____ _____

Phone: _____

Seal