American Legion Auxiliary

Virginia Girls State, Inc.

CONSENT TO MEDICAL TREATMENT AND HOSPITAL SERVICES

Name of participant: _____

Date of birth: _____

Parent's /Guardian's Name: _____

Parent's/Guardian's Phone: _____
Home Work Cell

Address: _____

City: _____ State: _____ Zip code: _____

Health insurance information:

Name of Insurer: _____

Group number: _____ Policy number: _____

(Please provide a copy of the front and back of your health insurance card.)

I, the undersigned parent/guardian, do 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 procedure, X-ray examination, emergency surgical treatment, or other hospital services.

I further grant permission for minor treatment, including First Aid medications, to be administered by the American Legion Auxiliary Virginia Girls State nurse.

No alterations to the terms stated above may be made. If you are not in agreement with these terms, please contact the director immediately by e-mail at **director@VaGirlsState.org** or through our website at **www.VaGirlsState.org**.

_____ _____
Parent's/Guardian's Signature Date

BRING THIS FORM WITH YOU TO LONGWOOD UNIVERSITY

Revised 12-15-2016