



**Consent to Medical Treatment and Hospital Services**

Name of Participant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_

Parent/Guardian Phone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Health Insurance Information

Name of Insurer \_\_\_\_\_ Policy holder \_\_\_\_\_

Group number \_\_\_\_\_ Policy Number \_\_\_\_\_

**Please provide a copy of the front and back of your health insurance card here.**

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 and over-the-counter medications as indicated, to be administered by the American Legion Auxiliary Virginia Girls State nurse or nurse practitioner.

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](mailto:director@VaGirlsState.org) or through our website at [www.VaGirlsState.org](http://www.VaGirlsState.org) to discuss.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

**BRING THIS COMPLETED FORM WITH YOU TO LONGWOOD UNIVERSITY TO CHECK IN.**