American Legion Auxiliary


Virginia Girls State, Inc.

# 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 _____

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/Guardian Signature Date

BRING THIS FORM WITH YOU TO LONGWOOD UNIVERSITY

Revised 2/14/2018