Medical History

Name of Participant _____ Date of Birth _____

Parent/Guardian name _____

Parent/Guardian Phone (Day) _____ (Evening) _____

Physician's name _____ Phone _____

Date of last physical exam _____ Is your daughter currently under a doctor's care Y / N

Does your daughter have a history of any of the following?

	YES	NO	Currently receiving treatment?
Allergies			
Asthma			
Anxiety or Depression			
Diabetes			
Eating disorder			
Food intolerance/allergy			
Gastrointestinal issues			
Heart problems			
Hearing or vision issues			
High blood pressure			
Immunocompromise			
Kidney problems			
Low blood pressure			
Migraines			
Musculoskeletal condition/injury			
Seizures			
Surgery			

Please provide information related to any items answered "YES" or any other medical condition not listed above.

_____

_____

_____

Please list all prescription and non-prescription medications and supplements along with the dose and frequency. Use the back of this page if needed.

Medication or supplement name	Dose	Frequency and when taken	Only as needed

Please inform our Virginia Girls State nurse of any medical concerns or allergies by email at nurse@vagirlsstate.org prior to arrival to the program.

Parent/Guardian Signature_____ Date _____

BRING THIS COMLETED FORM WITH YOU TO LONGWOOD UNIVERSITY TO CHECK IN.

Summer 2022