

First 3 Letters of Last Name: _____



AMERICAN LEGION JERSEY BOYS STATE

"A Week That Shapes the Future"

Sponsored by THE AMERICAN LEGION, DEPARTMENT OF NEW JERSEY
RIDER UNIVERSITY, Lawrenceville, NJ

www.aljbs.org

www.boysstate.com

facebook.com/ALJBS

@aljbs

@ALJBS

MEDICAL CERTIFICATE

THREE SECTIONS to be completed by APPLICANT, PARENT OR GUARDIAN & FAMILY PHYSICIAN

APPLICANT'S STATEMENT

NAME _____ PHONE # _____

(Area Code)

ADDRESS _____

(Street)

(City)

(Zip Code)

SPONSORED BY _____

(Post #)

(County)

(Date of Birth)

Have you ever had the following?

- | | | | |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> HERNIA * | <input type="checkbox"/> SKIN TROUBLE* | <input type="checkbox"/> VACCINATION AGAINST SMALLPOX* | <input type="checkbox"/> CURRENT MEDICATIONS: _____ |
| <input type="checkbox"/> ASTHMA* | <input type="checkbox"/> HEART TROUBLE* | <input type="checkbox"/> RECENT OPERATION* | _____ |
| <input type="checkbox"/> SMALLPOX | <input type="checkbox"/> EAR OR SINUS | <input type="checkbox"/> LUNG TROUBLE | _____ |
| <input type="checkbox"/> MUMPS | <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> INFANTILE PARALYSIS | <input type="checkbox"/> FOOD ALLERGY _____ |
| <input type="checkbox"/> MEASLES | <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> ALLERGY TO DRUGS _____ | _____ |

* Explain Details: _____

Have you been exposed to any contagious diseases within the last three weeks? Any recent travel outside the U.S.?

Have you ever been injured? (Explain nature and degree of injury)

SIGNATURE OF APPLICANT _____ DATE _____

PARENTAL PERMIT

The laws require that parental or guardian permission be obtained for medical attention to minors. Please indicate by an "X" in the appropriate square (s) what medical attention you desire the ALJBS EMS Staff, Local EMS and/or local Hospital to provide for your son. Please complete this form where indicated.

I HEREBY GIVE PERMISSION FOR SUCH MEDICAL ATTENTION AS INDICATED TO BE RENDERED TO MY SON _____

Put an "X" in one or more squares that you desire. MEDICAL ATTENTION CAN ONLY BE GIVEN IN THE AREAS YOU INDICATE BELOW.

- NO TREATMENT WHATSOEVER, REGARDLESS OF CIRCUMSTANCE
- DIAGNOSIS AND TREATMENT OF INJURIES (ALJBS EMS Staff, Local EMS and/or local Hospital)
- DIAGNOSIS AND TREATMENT OF ILLNESS (ALJBS EMS Staff, Local EMS and/or local Hospital)

It is understood and agreed that any pre-existing condition, known or unknown by us, of any nature whatsoever, that should manifest itself while the above stated applicant is in attendance at this session of ALJBS will not be the responsibility of ALJBS insofar as immediate emergency requirements may indicate.

First 3 Letters of Last Name: _____

PLEASE NOTE: ALJBS' medical insurance is a **secondary policy**. Our coverage picks up where the delegate's coverage leaves off. **IN THE EVENT THAT THE DELEGATE DOES NOT HAVE COVERAGE, ALJBS' COVERAGE BECOMES THE PRIMARY COVERAGE.**

OUR ACCIDENT AND HEALTH AND/OR MEDICAL EXPENSE INSURANCE COMPANY IS:

POLICY NUMBER _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ HOME PHONE # _____
(Area Code)

POLICY HOLDER RELATIONSHIP _____ MOBILE PHONE # _____
(Mother, Father, Guardian) (Area Code)

PARENT/GUARDIAN SIGNATURE _____ INITIALS _____ DATE _____

PHYSICIAN'S STATEMENT

PLEASE NOTE: If you have a school or sports physical from the past 12 months, that may be attached in lieu of the section below. However, please fill out the other sections above this section!

NOTE TO PHYSICIAN:

Applicant will do much walking and negotiation of stairs in a fast-moving, tightly-scheduled weeklong program. He must be able to communicate easily. Please indicate whether he has any temporary or permanent disability which would in any way hinder his complete participation. Provide a short statement on current health history:

HEART _____ LUNGS _____ THROAT _____

SKIN _____ EYES _____ EARS _____

HERNIA: DATE, TYPE, DEGREE _____

Recent exposure to or contracting of communicable disease? _____

Date of last tetanus booster: _____

Does he have any possible recurring injury? _____

Any reason for NOT participating in athletics? _____

Reaction to drugs or bleeding problems? _____

Does he have any dormant disease or condition that could manifest itself while attending this session?

Other comments (Feel free to attach additional sheets): _____

PRINT PHYSICIAN NAME/TITLE _____

OFFICE NAME _____ PHONE # _____
(Area Code)

ADDRESS _____ FAX # _____

PHYSICIAN SIGNATURE _____ DATE _____