

**MEDICAL FORM**

**SCAN AND UPLOAD THIS MEDICAL FORM WITH ONLINE REGISTRATION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Participant School**

**(PLEASE PRINT)**

**(Examination must be by a licensed physician within one year preceding the opening of Girls State.)**

**School Sports Physical Examination may be used if exam is after July 1, 2023.**

**MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Past** | **Present** |  | **Past** | **Present** |
| Asthma |  |  | Heart Disease |  |  |
| Anemia |  |  | Kidney Disease |  |  |
| Broken Bones |  |  | Leukemia |  |  |
| Cancer |  |  | Measles |  |  |
| Chicken Pox |  |  | Mononucleosis |  |  |
| Congenital Defects |  |  | Mumps |  |  |
| Depression |  |  | Neurological Disease |  |  |
| Diabetes |  |  | Pregnancy |  |  |
| Diphtheria |  |  | Psychiatric Disease |  |  |
| Dizziness |  |  | Pulmonary Disease |  |  |
| Drug Problems |  |  | Rheumatic Fever |  |  |
| Eating Disorder |  |  | Rheumatoid Arthritis |  |  |
| Ear/Nose/Throat Problems |  |  | Rubella |  |  |
| Emotional Problems |  |  | Scarlet Fever |  |  |
| Food Allergies  Headaches |  |  | Seizures  Small Pox |  |  |
| Hepatitis |  |  | Stomach Problems |  |  |
| Hypertension |  |  | OTHER (List) |  |  |
|  |  |  |  |  |  |

**Explain all “YES” answers:**

Are you currently under a doctor’s care? If so, for what?

Are you taking any prescription or over the counter medications? If so, list drug, dosage, frequency, and reason.

Please list any surgeries you have had and the date.

Date of last physical examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that this girl is free from contagious disease and that she is physically able to participate in all activities of the American Legion Auxiliary WV Rhododendron Girls State program, including athletic events other than those listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D./D.O. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date