AMERICAN LEGION AUXILIARY
Granite Girls State
Health Record

Name: _____ Date of Birth: _____

Address: _____

Telephone #: _____

Physician's Name: _____ Telephone #: _____

Emergency #: _____

**ALLERGIES**: (medications, food, inhalants, etc.) and **TYPE of REACTION**:

General Physical condition: (circle one) excellent good fair poor

**CURRENT MEDICAL CONDITIONS**: (chronic illnesses and health problems treated in the past 6 months)

**ACTIVITY RESTRICTIONS OR LIMITATIONS:**

**MEDICATIONS:** Please list all over the counter and prescription drugs which the student regularly uses.

| NAME | DOSAGE | FREQUENCY | REASON FOR USE |
|---|---|---|---|
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Date of last Tetanus Shot: _____ Date of Last Physical Exam: _____

Last physical exam completed by: _____

**Signature of Physician** _____ Date: _____

The undersigned parents (surviving parent or guardian) of: _____ hereby consent and grant permission to the furnishing of medical treatment and hospital services as ordered or recommended by a qualified attending physician, should the necessity of medical care arise.

Hospitalization Insurance Co. Name: _____

Policy Holder's Name: _____

**Signature of Parent or Guardian:** _____