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?

( ) HERNIA *	( ) SKIN TROUBLE*	( ) VACCINATION AGAINST SMALLPOX*	( ) CURRENT MEDICATIONS: _____
( ) ASTHMA*	( ) HEART TROUBLE*	( ) RECENT OPERATION*	_____
( ) SMALLPOX	( ) EAR OR SINUS	( ) LUNG TROUBLE	_____
( ) MUMPS	( ) SCARLET FEVER	( ) INFANTILE PARALYSIS	( ) FOOD ALLERGY _____
( ) MEASLES	( ) DIPHTHERIA	( ) 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.

 Parent/Guardian Initials: _____

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

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** _____