AMERICAN LEGION AUXILIARY
Granite Girls State
Health Record

Name:_____ Date of Birth_____

Address_____

Telephone Number_____

Physician's Name_____ Telephone Number_____

Emergency Number_____

Allergies: (medications, foods, 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 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

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, should the necessity of medical care arise, to the furnishing of medical treatment and hospital services as ordered or recommended by a qualified attending physician.

Hospitalization Insurance Co. Name_____

Policy Holder's Name_____

Signature of Parent or Guardian_____