AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE UNIT/POST CONSENT FORM

**THIS APPLICATION IS NOT CONSIDERED APPROVED**

**UNLESS ACCOMPANIED BY AN ONLINE APPLICATION.**

**Applications are due to the ALALGS Commission no later than June 1, 2023.**

Sponsoring Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print) (Name) (Phone Number)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Address)

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICANT MUST BE A UNITED STATES CITIZEN.**

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Please Type or Print

DELEGATES NAME; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **LAST FIRST MIDDLE**

**THIS APPPLICATION MUST BE COMPLETED, SIGNED, AND TUITION PAID BY JUNE 1, 2023**

 Please Mail to: AMERICAN LEGION AUXILIARY

 ATTN: ALA LAUREL GIRLS STATE

 P.O BOX 266

 ROCKY HILL, CT 06067-0266

**TO BE COMPLETED BY APPLICANT’S HIGH SCHOOL GUIDANCE COUNSELOR.**

NAME OF SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street or Rural Route) (City/Town) (Zip)

As a Guidance Counselor of the above-named school, I recommend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a member of the Junior Class, as a Representative to the American Legion Auxiliary Laurel Girls State. I believe that they are a responsible citizen who has demonstrated leadership, good academics, and an interest in government.

 DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

An Alternate should be selected by the school in case the Applicant cannot attend the entire week. In this event, please notify the Chairman/Director @ 203-843-0477 by June 15th. The Alternate will then be notified as soon as possible so that they may be prepared to attend the entire week.

NAME OF ALTERNATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (Middle Init) ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street or Rural Route) (City/Town) (Zip)

TELEPHONE NUMBER: ( ) -

AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE WAIVER AND IDEMNIFICATION

I, the undersigned parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for a valuable consideration, waive and agree to be responsible for and to indemnification and save harmless, the American Legion Auxiliary , Department of Connecticut, Inc. and all its subsidiary organizations thereof, Post University, the organization known as American Legion Auxiliary Laurel Girls State, Inc., and all of their agents, representatives, assistants and servants, from any and all claims, damages, or cause of action arising out of injuries which may be received by my daughter or ward while at The University of New Haven in West Haven, June 24th through 29th or on the way thereto or therefrom.

DATE: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

PARENT OR GUARDIAN’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE CONSENT TO MEDICAL TREATMENT AND HOSPITAL SERVICES

This is to certify that I, the undersigned parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do, in the event that my child becomes a participating member of the American Legion Auxiliary Laurel Girls State, consent and grant permission, should the necessity of medical care arise, as recommended by a qualified attending physician, including administration of an anesthetic,

lab procedures, medical or surgical treatment, X-ray examination or other hospital services.

Dated this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_ 2023

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or guardian Telephone number

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street) (City/Town) (Zip)

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**IMPORTANT**: ALL DELEGATES AND COUNSELORS ARE INSURED BY THE

 AMERICAN LEGION AUXILIARY AND EVERY PRECAUTION IS TAKEN

 TO AVOID SICKNESS AND ACCIDENTS. (THIS DOES NOT INCLUDE

 TRANSPORTATION TO AND FROM LAUREL GIRLS STATE.)

Dear Delegate and Parents/Guardians,

 It is critical for you to understand how important your selection to the American Legion Auxiliary Laurel Girls State program is. The program at ALA Laurel Girls State is intense and is planned to fill the entire week with speakers, elections, bill writing, and debate. This means you must be present the entire week.

 This agreement to attend ALA Laurel Girls State the entire week must be signed by the delegate and their parents/guardians. There must be no misunderstanding about missing an hour or two for various reasons. We have structured this program so that missing any period of time is critical.

Sincerely,

Monica Mordowanec

Chairman/Director

ALA Laurel Girls State

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delegate:** I agree to spend the ENTIRE week (June 24th through 29th) at ALA Laurel Girls State.

Delegate’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents/Guardians:**

I agree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will spend the ENTIRE week (June24th through 29th) at ALA Laurel Girls State.

Parents/Guardians Signatures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **WAIVER FOR PHOTOGRAPHIC USE**

 THE AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE AND UNIVERSITY OF NEW HAVEN WOULD LIKE TO TAKE PICTURES OR VIDEO RECORD THE 2023 SESSION.

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_, GIVE MY PERMISSION TO THE AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE AND POST UNIVERSITY TO USE MY NAME AND PHOTOGRAPHS FOR NEWS RELEASES AND THE ALALGS WEBSITE FOR PROMOTIONAL PURPOSES DURING THE WEEK AND FOLLOWING THE SESSION.

 SIGNATURE OF PARENT / GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE 2023 MEDICAL FORM

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (Middle Init)

DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Month) (Day) (Year)

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street or Rural Route)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (City/Town) (Zip)

PARENT OR GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **TO BE COMPLETED BY A LICENSED PHYSICIAN**

List any allergies to medications, foods, bee stings, poison ivy, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications currently being taken:

 NAME OF MEDICATION DOSAGE PRESCRIBED FOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Physical Restrictions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY - If ‘Yes’, please list medications taken

Any recent injury, illness or disease? Y\_\_\_\_N\_\_\_\_

A chronic or recurring illness? Y\_\_\_\_N\_\_\_\_

Wear eyeglasses or contacts? Y\_\_\_\_N\_\_\_\_

Ever had seizure? Y\_\_\_\_N\_\_\_\_

Ever had high blood pressure? Y\_\_\_\_N\_\_\_\_

Have diabetes? Y\_\_\_\_N\_\_\_\_

Abnormal menstrual? Y\_\_\_\_N\_\_\_\_

Have a heart murmur? Y\_\_\_\_N\_\_\_\_

Have asthma? Y\_\_\_\_N\_\_\_\_

History of bed wetting? Y\_\_\_\_N\_\_\_\_

Had back problems? Y\_\_\_\_N\_\_\_\_

ALL VACCINATIONS ARE CURRENT AND COMPLETE YES \_\_\_\_\_ NO \_\_\_\_\_

ACCORDING TO ALL STATE REGULATIONS?

Date of Last Tetanus Shot: \_\_\_/\_\_/\_\_

PHYSICAL EXAMINATION:

 Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Eyes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ears \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Throat \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TESTS: Tuberculin Test \_\_\_\_\_\_\_\_\_\_\_\_

Are they a Sleepwalker? Y\_\_\_\_N\_\_\_\_

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DATE OF EXAMINATION: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LICENSE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IN THE STATE OF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS OF PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER: ( ) -

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**THIS EXAMINATION MUST BE WITHIN 1 YEAR OF JUNE 22, 2023**

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ALL MEDICAL FORMS WILL BE DUE JUNE 13, 2023. THE DELEGATE AND THEIR PARENTS OR GUARDIAN ARE RESPONSIBLE FOR INSURING THAT THE RECORDS ARE PROVIDED ACCURATELY AND COMPLETELY.

ALL MEDICAL FORMS MUST BE SEALED IN AN ENVELOPE AND MAILED TO:

 American Legion Auxiliary

ALALGS

 P.O. Box 266
Rocky Hill, CT 06067-0266

THE DELEGATE’S NAME MUST APPEAR ON THE OUTSIDE OF THE ENVELOPE.