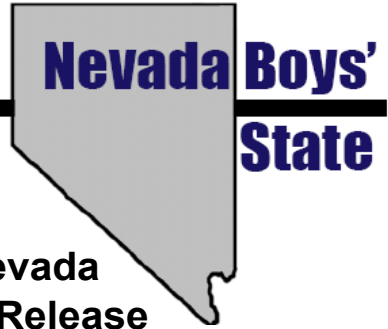




AMERICAN LEGION



The American Legion Department of Nevada
Nevada Boys' State Publicity and Medical Release

Please print all responses:

Delegate's name: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Emergency Contact/Phone Number: \_\_\_\_\_

PUBLICITY RELEASE: By signing below I consent to my son's picture, sound or video recording or other likeness being used on the American Legion Nevada Boys' State website, any media now known or devised in the future without any compensation other than the training my son receives as a delegate at American Legion Nevada Boys' State.

MEDICAL HISTORY:

Family Doctor's Name \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Has he been exposed to any contagious disease within the last month? \_\_\_\_\_ If so, when and what? \_\_\_\_\_

Please list all medications and dosage frequencies for the delegate: \_\_\_\_\_

Please list any allergies the delegate has: \_\_\_\_\_

Is there any known physical condition that would require specific accommodations? If, so how should it be addressed? \_\_\_\_\_

PRIMARY INSURANCE: Please note, insurance is not a requirement for attendance at Nevada Boys' State.

Insurance Company Name: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

MEDICAL RELEASE - Authorization to Consent to Medical Treatment: A Medical Release is required and may be needed if a delegate becomes ill or is injured and requires medical treatment. In some cases, when a delegate is taken to a doctor or hospital, they will not provide treatment until they receive the authority to do so from the minor's parent or guardian.

I, \_\_\_\_\_ of \_\_\_\_\_, am the \_\_\_\_\_ having

legal custody of \_\_\_\_\_, a minor born \_\_\_\_\_ I authorize the Nevada Boys'

State Director and/or adult members of the staff in whose care my minor has been entrusted, to consent to any medical or surgical diagnostic or treatment, and hospital care, to be rendered to the minor under the general or special supervision, and on the advice of any physician or surgeon licensed to practice in the State of Nevada.

Dated, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, Signature X \_\_\_\_\_

Mail or Fax Form and copy of Insurance Card to:
P.O. Box 137 Reno, Nevada 89501
888-646-6594 Please: No Cover Sheet