

MONTANA BOYS STATE MEDICAL QUESTIONNAIRE

MONTANA AMERICAN LEGION BOYS STATE

P.O. BOX 6075 Helena, MT 59604

(You MUST Bring This Form With You!)

Dear Parents:

Every precaution is taken to avoid accidents and sickness at Montana Boys State. Participants who do not already have group accident-sickness medical insurance coverage's are insured under a group policy underwritten by Sentry Insurance. The Sentry policy is **excess** coverage to any other valid and collectible group insurance plan. (This exclusion does not apply to individual accident and sickness policies.) Should any unforeseen need arise for this insurance program, more detailed information will be sent directly to you at that time by Montana Boys State.

CONSENT TO MEDICAL TREATMENT AND HOSPITAL SERVICES

This will certify that we (I), the undersigned parent(s) or guardian(s) of _____ do, in the event that our (my) son becomes a participating member of the American Legion's Montana Boys State, 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, including the administration of an anesthetic, laboratory procedures, medical or surgical treatments, X-ray examination or other hospital services.

WAIVER OF CLAIM

This will further certify that we (I), the undersigned, in consideration of the benefits to be derived by our (my) son, in the event that he is a member of the American Legion's Montana Boys State, do hereby release and discharge The American Legion, its officers, agents, instructors and employees from any and all claims, demands, damages, suits, actions or causes of action which we (I) may, can or shall have by reason of any illness, injury or accident incurred or suffered by said son while traveling to, attendance at or participation in The American Legion's Montana Boys State program from the time of his departure from home until his return thereto.

INSURANCE INFORMATION

(To be completed only if parent(s) carry a GROUP medical insurance plan.)

Name of parent(s) group
medical insurance
carrier: _____

Policy or Certificate No. _____

Parent to whom policy
was issued: _____

Employer to whom
policy was issued:

MEDICAL STATEMENT

Your son is about to participate in an active and strenuous 7 day program involving 500 boys (answer questions on back if necessary).

Does he have any communicable diseases?

Is there a chronic disease that might worsen?

Should his physical activities be limited?

Are there any other restrictions?

_____ Dated this _____ of _____, 20____

Signature of Father or Guardian Signature of Mother or Guardian