AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE OFFICIAL 2020 APPLICATION FORM

**THIS APPLICATION IS NOT CONSIDERED APPROVED**

**UNLESS SIGNED BY A SPONSORING UNIT.**

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

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

(Please Print) (Name) (Phone Number)

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

 (Email Address)

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

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

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Please Type or Print

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

 (Last) (First) (Middle Init)

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

 (Street or Rural Route)

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

 (City/Town) (Zip)

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

 (Month) (Day) (Year)

CONTACT PHONE NUMBER: ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CONTACT PHONE NUMBER - Day: ( ) - Night: ( ) -

PARENT’S OR GUARDIAN’S ADDRESS IF OTHER THAN AS SHOWN ABOVE:

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

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

I AM AWARE OF THE FACT THAT THE AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE PROGRAM IS DEVOTED TO CITIZENSHIP TRAINING. I WILL COOPERATE WITH AND OBEY ALL THE RULES AND REGULATIONS OF THE AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE, INCLUDING SALUTING THE FLAG AND RESPECTING THE MOMENTS OF PRAYER. I AM ALSO AWARE THAT THE USE OR POSSESSION OF WEAPONS, ALCOHOL, OR DRUGS WILL RESULT IN MY IMMEDIATE DISMISSAL. I WILL ATTEND THE FULL SESSION OF LAUREL GIRLS STATE FROM JUNE \_\_\_\_\_\_\_\_\_\_\_\_\_2020\_TO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2020.

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

 (SIGNATURE OF APPLICANT)

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

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

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

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

CONTACT PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As **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 she is a responsible citizen who has demonstrated leadership, B average or better, and an interest in government.

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

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

An Alternate should be selected by the school in case the Applicant cannot attend the entire week. In this event, please notify the Chairman Karen L Thompson 203-233-0956/Director Sue Larsen 860-644-8859 by June \_\_\_. The Alternate will then be notified as soon as possible so that she 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: ( ) -

**THIS APPPLICATION MUST BE COMPLETED, SIGNED, AND TUITION PAID BY May 1, 2020**

 Please Mail to: AMERICAN LEGION AUXILIARY

 ATTN: LAUREL GIRLS STATE

 P.O BOX 266

 ROCKY HILL, CT 06067-0266

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, the hosting University, the organization known as American Legion Auxiliary Laurel Girls State, 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 during the duration of the program or on the way there to or there from. In the event a field trip is planned you will be notified

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 daughter 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 \_\_\_\_\_\_\_\_\_ 2020

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

Signature of parent or guardian Contact phone number

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

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

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 her parents/guardians. BOTH parents/guardians must sign if both have custodial rights. 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,

Karen L Thompson Sue Larsen

Chairman Director

ALA Laurel Girls State

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

**Delegate:** I agree to spend the ENTIRE week of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at ALA Laurel Girls State.

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

**Parents/Guardians:**

I agree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will spend the ENTIRE week of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at ALA Laurel Girls State.

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

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

 Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **WAIVER FOR PHOTOGRAPHIC USE**

 THE AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE AND POST UNIVERSITY WOULD LIKE TO TAKE PICTURES OR VIDEO RECORD THE 2020 SESSION.

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_, GIVE MY PERMISSION TO THE AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE AND THE HOSTING 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMERICAN LEGION AUXILIARY LAUREL GIRLS STATE 2020 MEDICAL FORM

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

 (Last) (First) (Middle Init)

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

 (Month) (Day) (Year)

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

 (Street or Rural Route)

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

 (City/Town) (Zip)

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

CONTACT PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Is She 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 2 YEARS OF JUNE 30, 2020**

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ALL MEDICAL FORMS WILL BE DUE JUNE 8, 2020. THE DELEGATE AND HER 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 Nurse

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

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