# INSURANCE, MEDICAL & PHYSICAL

This form is to be completed by the Missouri Boys State (MBS) Citizen, Parent/Guardian and Family Physician. v.04/18
No applicant will be admitted without this completed and signed form. BE SURE TO BRING IT WITH YOU TO MISSOURI BOYS STATE.

## GENERAL MBS CITIZEN INFORMATION

First Name | Middle Name | Last Name

Mailing Address | City

State | Zip Code | Birth Date (MM/DD/YYYY) | Parent/Guardian Day/Cell Phone (including area code) | Alt. Emergency Day/Cell Phone (including area code)

Past Medical History includes (i.e., past illnesses or medical problems):

Please describe any Allergies to Medications and/or Foods:

****If accommodations are needed, call the Missouri Boys State Headquarters at 1-877-342-5627 prior to the first day of the program.****

Specify name of medication(s), dosage, and reason prescribed (attach additional sheet if necessary):

**INSURANCE:** We hereby state that the MBS Citizen is covered by medical insurance listed herein (if any). We understand and agree that said insurance (if any) will be the primary insurance for the MBS Citizen while a participant at Boys State. We agree to cooperate fully with the staff of Boys State and the insurance company which provides secondary medical insurance coverage for Boys State by providing information, assistance in filing claims with our insurance company and in any other manner to assist so that the cost of any medical care rendered for injury or illness will be promptly paid to the supplier of medical care for the MBS Citizen.

### Insurance Information

*(Note: Please provide insurance information, if any. If none, enter "None.")*

MBS Citizen's Insurance Company | Policy Number | Medication/Prescription Policy Number (if different)

Policy Holder's Full Name | Policy Holder's Date of Birth (MM/DD/YYYY)

**MEDICAL AUTHORIZATION:** In the event of treatment by WESTERN MISSOURI MEDICAL CENTER or the UNIVERSITY OF CENTRAL MISSOURI STUDENT HEALTH CENTER, and/or any other medical provider referred by the foregoing as well as physicians employed by or attending said institutions (hereinafter "Medical Providers"), we hereby authorize and request the Medical Providers, to furnish to

(name of family physician) _____ pertinent information regarding MBS Citizen's case history and treatment and examination which MBS Citizen received, including copies of hospital and medical records, x-rays, etc.

We hereby authorize the Boys State Director, Dean of Counselors or Dean of Operations or any of their designated representatives (collectively known as "Boys State Staff") to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment of hospital care to be rendered to the MBS Citizen if necessary and when efforts to contact me are unsuccessful.

We further consent to the examination of the minor child by a duly licensed physician without contacting me, for the purpose of ascertaining whether or not any treatment or care may be required, and what, if any, activities, or limitations thereon, may be appropriate for my child during Boys State.

We understand and acknowledge that the MBS Citizen's health information may be protected by federal privacy standards. We consent to and authorize the Medical Provider to disclose protected health information concerning the MBS Citizen to Boys State Staff for any lawful purpose. We agree and acknowledge that any co-payments or co-insurance charges related to the primary insurance applicable to the MBS Citizen are our responsibility and, in the event any such payments are made by MBS, we agree to reimburse MBS for the same.

## PARENT or GUARDIAN

STATE OF _____ )
)ss.
COUNTY OF _____ )

I hereby state that I am a parent or legal guardian having custody of _____

child age _____, born on _____, 20____, who resides with me in _____,
City, State and Zip Code

and that I have read the above statements and hereby consent and agree to such release and authorizations.

PARENT/GUARDIAN SIGNATURE: _____ Date _____

or

MBS CITIZEN SIGNATURE: _____ Date _____
(If 18 years of age or older, or legally declared to be an adult.)

On this _____ day of _____, 20____
before me personally appeared the above named persons who
stated they signed the forgoing document as their free act and deed. _____ _____
Notary Public | My commission expires on

## PHYSICIAN STATEMENT

Please complete and sign this statement or attach a signed and dated physical form completed within the previous 12 months.

Heart: _____ Lungs: _____ Throat: _____ Skin: _____

Eyes: _____ Ears: _____ Hernia: _____

Immunizations comply with Missouri State Law? Y N

MBS is a week-long democracy learning program with a limited organized athletics program comparable to high school gym class. Is there a Medical reason this individual should NOT participate or require a specific accommodation? Y N

If "Yes," explain: _____

Should participation be prohibited due to any communicable diseases or other medical condition(s)? Y N

If "Yes," explain: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Doctor's Telephone Number | Street Address | City, State, Zip