Missouri Area Event Permission & Medical Form

THIS FORM MUST BE FILLED OUT **ENTIRELY** IN ORDER FOR THE ALATEEN MEMBER TO PARTICIPATE

PARENT(S) /AUTHORIZED GUARDIAN: Please read, complete, sign this form and keep a copy for your records

ALATEEN: Please return this completed form to your Alateen Group Sponsor or Accompanying AMIAS **PRIOR** to departure date.

GROUP SPONSOR/ACCOMPANYING AMIAS: Keep the **original** copy of this form in your possession for the Duration of time the Alateen member is in your charge.

ALATEEN MEMBER'S INFORMATION

First and Last Name: _____

Address: _____

City: _____State:_____Zip:_____

Phone Number: ( ) _____E-mail Address: _____

Date of Birth: _____ Age at time of event: _____

Male: _____ Female: _____

1st GROUP SPONSOR/ACCOMPANYING AMIAS INFORMATION

First and Last Name: _____

Address: _____

City: _____ State: _____Zip:_____

Phone Number: _____ E-Mail Address: _____

_

2nd GROUP SPONSOR/ACCOMPANYING AMIAS INFORMATION

First and Last Name:_____

Address: _____

City: _____ State: _____Zip:_____

Phone Number: _____ E-Mail Address: _____

I (parent/authorized guardian) understand that last minute changes may occur in accompanying AMIAS. If so, an attempt will Be made to notify the parent/authorized guardian. **Initial** _____ **(Parent/Authorized Guardian)**

EVENT INFORMATION

Name of Event: _____

Location of Event: _____

Address of Location: _____

Phone Number of Location: ( ) _____

Date & Time & Place of Departure: _____

Date & Time & Place of Return: _____

Mode of Transportation: _____

(include make, model, year of vehicle & license plate number)

Approved by Missouri Area Assembly on Nov 08, 2015
Ratified by Missouri Alateens at Super Sunday on Mar 13, 2016
Updated by Alateen Coordinator, AAPP & Serenity Patrol Coordinator Aug 10,2017

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PARENT/ AUTHORIZED GUARDIAN INFORMATION

First and Last Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone Number: Home ( ) _____ Work ( ) _____

E-mail address: _____

During this event, I can be reached at: ( ) _____

NEAREST RELATIVE NOT LIVING WITH THE ALATEEN MEMBER OR PARENT/ AUTHORIZED GUARDIAN

First, Last Name & Relationship: _____

Address: _____

City: _____State: _____ Zip: _____

Phone Number: Home ( ) _____ Work ( ) _____

HOLD HARMLESS STATEMENT

For and in consideration of being allowed to participate in this event the undersigned, as the parent/authorized guardian of aforementioned Alateen member, I realize I am responsible for payment of any medical services required and obtained on said member's behalf. I further hold harmless the event attended by my child and

_____

_____

(Insert name and WSO registration number (if known) of group, district, Al-Anon Information Service office, and/or Area)
or authorized representative thereof, should any harm come to my child as a result of his/her participation in this activity or procurement of medical treatment. I hereby also release any and all listed entities from any liability for any loss or damages on account of any injury to the person or personal property of my child including any injury or death caused by negligence or otherwise while my child is engaged in any activities related hereto or while traveling to and from such event, including any and all legal action as a result of my Alateen's/my participation in the _____ event.

Parent/Authorized Guardian/ Signature:_____ Date: _____

PARENT/ AUTHORIZED GUARDIAN PERMISSION

I, _____ hereby grant permission to _____
(Parent/Authorized Guardian Name) (Alateen member's name)

To travel to and from and to participate in _____ under the supervision of
(Event Name)

1st _____ And 2nd _____
(Group Sponsor /Accompanying AMIAS Name) (Group Sponsor /Accompanying AMIAS Name)

On _____ (Date of Event including Travel Time)

**** I have read the Missouri Area Event Behavior Standards with my Alateen and we agree to abide by them. ****

Alateen Signature: _____

Parent/ Authorized Guardian Signature: _____

****To be signed in the presence of the Group Sponsor/Accompanying AMIAS****

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AUTHORIZATION TO OBTAIN MEDICAL CARE

In order for anyone to obtain medical care for another person who is not a family member, this form must be filled out entirely and bear the original notary seal.

When distance and time may compromise acquisition of timely medical attention, **attendance to a fellowship event can be prohibited if this form is not properly filled out and notarized.**

PARTICIPANT'S NAME: (Alateen member or Group Sponsor/Accompanying AMIAS): Circle One

_____

DISEASES/MEDICAL CONDITIONS

Participant has (had) the following diseases or problems:

Heart Trouble	_____	Hives	_____	High Blood Pressure	_____
Tuberculosis	_____	Epilepsy	_____	Low Blood Pressure	_____
Stomach Ulcers	_____	Diabetes	_____	Liver Trouble (Hepatitis)	_____
Asthma	_____			Fainting Spells or Seizures	_____

Other (Please Describe) _____

_____

ALLERGIES

Participant has had allergic reaction from the following: (please check):

Penicillin	_____	Sulphur Drugs	_____	Insect Bites	_____	Latex	_____
Local Anesthetics	_____	Sedatives	_____	Pollens	_____		
Aspirin	_____	Bee Stings	_____	Foods	_____		

Foods (please list) _____

Other (please describe) _____

CURRENT MEDICATIONS

Please list all prescriptions & over-the-counter drugs. These medications MUST be in their original container(s) with labels firmly in place. Medications listed below MUST match medications being taken at the time of the event and that Alateens turn into their accompanying AMIAS upon departure to any Area Event. Any changes to the list below, requires a NEW completed Medical Form. Participant is currently using the following medications:

_____

_____

EVENT MEDICAL KIT contains: acetaminophen, ibuprofen, anti-acids, and triple antibiotic ointment

Participant **MAY** or **MAY NOT** have as needed. (Please **CIRCLE ONE**)

OTHER CONDITIONS OR PROBLEMS

Participant has the following condition or problems not listed above that you should know about: (please explain)?

_____

_____

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MEDICAL INSURANCE INFORMATION

You must provide medical insurance information in the space below:

Name of Insurance Co: _____

Insured's Name: _____ Date of Birth: _____

Employer Name: _____

Employee Name: _____ Date of Birth: _____

Member ID Number: _____ Group ID Number: _____

(Or attach a medical coupon if covered by Medicaid)

NOTARY STATEMENT

Authorization to Obtain Medical Care is not valid without a signed and sealed Notary Statement.

State/Province of _____

County of _____

(Group Sponsor/Accompanying AMIAS / or Responsible Party Name) _____

And or _____is/are authorized upon my signature below to obtain any Medical care necessary for the duration of the above stated function on behalf of

(Participant's Name) _____

Who is (state relationship - self, son, daughter) my _____ .

Dated this _____ day of _____ 20_____

_____ _____

(Signature – if 18 or over) **(Signature of Parent or Authorized Guardian, if under 18)**

Before me, the above signed authority, on this day personally appeared _____ , to me known and known by me to be the person who signed the above authorization, and acknowledged to me that (s)he executed the same for the purpose therein stated.

WITNESS my hand and seal this _____ day of _____ 20_____

NOTARY PUBLIC: _____

My Commission Expires: _____ Seal:

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