

# INFORMATION AND PERMISSION FORM

**This form must be filled out entirely in order for the Alateen member to participate.**

*ALL INFORMATION IS TO BE PRINTED OR TYPED.*

**PARENTS:** Please read, complete and sign this form and keep a copy for your records.

**ALATEENS:** Please return this completed form to your sponsor or accompanying adult.

**SPONSOR/ESCORT:** Keep the original copy of this form in your possession for the duration of the time the Alateen member is in your charge.

## **ALATEEN MEMBER'S INFORMATION**

First and Last Name: \_\_\_\_\_

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

City, State, Zip Code: \_\_\_\_\_

Phone Number (include area code): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **SPONSOR/ESCORT INFORMATION**

First and Last Name: \_\_\_\_\_

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

City, State, Zip Code: \_\_\_\_\_

Phone Number (include area code): \_\_\_\_\_

## **EVENT INFORMATION**

Name of Event: \_\_\_\_\_

Location of Event: \_\_\_\_\_

Address of Location: \_\_\_\_\_

Phone Number of Location: \_\_\_\_\_

Date, Time and Place of Departure: \_\_\_\_\_

Date, Time and Place of Return: \_\_\_\_\_

Mode of Transportation: \_\_\_\_\_

(include make, model, year of vehicle and license plate information)

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## CUSTODIAL PARENT/GUARDIAN INFORMATION

First and Last Name: \_\_\_\_\_

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

City, State, Zip Code: \_\_\_\_\_

Home Phone Number (include area code): \_\_\_\_\_

Work Phone Number (include area code): \_\_\_\_\_

During this event, I can be reached at: \_\_\_\_\_

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

First and Last Name and Relationship: \_\_\_\_\_

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

City, State, Zip Code: \_\_\_\_\_

Home Phone Number (include area code): \_\_\_\_\_

Work Phone Number (include area code): \_\_\_\_\_

## HOLD HARMLESS STATEMENT

As the parent guardian of the aforementioned Alateen member, I am responsible for the 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.

Parent/Guardian signature and date: \_\_\_\_\_

## PARENTAL PERMISSION (to be signed by parent or legal guardian)

I, \_\_\_\_\_ hereby grant permission to \_\_\_\_\_ to travel to and from and to participate in \_\_\_\_\_ under the supervision of \_\_\_\_\_ on \_\_\_\_\_.

Parent/Guardian signature and date: \_\_\_\_\_

# MEDICAL FORM

## 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.

## DISEASES/MEDICAL CONDITIONS

(Alateen member or sponsor/escort name) \_\_\_\_\_ has (had) the following diseases or problems:

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

## ALLERGIES

(Alateen member or sponsor/escort name) \_\_\_\_\_ has had allergic reactions to the following:

Penicillin	_____	Local Anesthetics	_____
Aspirin	_____	Sulfa Drugs	_____
Sedatives	_____	Bee Stings/Insect Bites	_____
Pollens	_____		
Foods (please list)	_____		
Other (please describe)	_____		

## PHYSICIAN'S INFORMATION

Doctor's Name: \_\_\_\_\_

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

Phone and Emergency Number: \_\_\_\_\_

## CURRENT MEDICATIONS

(Alateen member or sponsor/escort name) \_\_\_\_\_ is currently using the following medications: \_\_\_\_\_

(Please list all prescription and over-the-counter drugs, including dosages. These medications *must* be in their original containers with labels firmly in place.)

# MEDICAL FORM

## OTHER CONDITIONS OR PROBLEMS

(Alateen member or sponsor escort name) \_\_\_\_\_ has the following condition or problems that you should know about (please explain): \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

You must provide medical insurance information in the space below.

Name of insurance company: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employee: \_\_\_\_\_

Group ID Number (or attach a medical coupon if covered by Medicaid): \_\_\_\_\_

## NOTARY STATEMENT

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

State of \_\_\_\_\_

County of \_\_\_\_\_

(Sponsor/Escort Name) \_\_\_\_\_ is authorized upon my signature below to obtain any medical care necessary for the duration of the above stated function on behalf of (Participants Name) \_\_\_\_\_ who is (state relationship – self, son, daughter) my \_\_\_\_\_.

Dated this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
(Signature – if 18 or older)

\_\_\_\_\_  
(Signature of parent or 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 acknowledge to me that (s)he executed the same for the purpose therein stated.

WITNESS my hand and seal this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

NOTARY PUBLIC

My commission Expires: \_\_\_\_\_

Seal: \_\_\_\_\_

\_\_\_\_\_  
Notary Public's Signature