

NYN ALATEEN CONFERENCE PARENT / MEDICAL CONSENT FORM

FORM A: INFORMATION AND PERMISSION FORM

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This Form Must Be Filled Out Entirely In Order For The Alateen Member To Participate

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

ALATEENS: Please return this completed form to your Alateen Group Sponsor or accompanying AMIAS.

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

2020 Salt City Mid-Winter Roundup (With Al-Anon and Alateen Participation)

ALATEEN MEMBER'S INFORMATION

First and Last Name: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Phone Number: () _____

Date of Birth: _____

SPONSOR/ADULT ESCORT INFORMATION

First and Last Name: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Phone Number: () _____

EVENT INFORMATION

Name of Event: 2020 Salt City Mid-Winter Roundup – February 7th, 8th and 9th, 2020

Location of Event: HOLIDAY INN

Address of Location: 441 ELECTRONICS PARKWAY, LIVERPOOL, NY 13088

Phone Number of Location: (315) 457-1122 _____

Date & Time & Place of Departure: _____

Date & Time & Place of Return: _____

Mode of Transportation: _____

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

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CUSTODIAL PARENT/GUARDIAN INFORMATION

First and Last Name: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Phone Number: Home () _____ Work () _____

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

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

First, Last Name & Relationship: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Phone Number: Home () _____ Work () _____

HOLD HARMLESS STATEMENT

As the parent/guardian of aforementioned Alateen member, 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,

_____ 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: _____ Date: _____

PARENTAL PERMISSION (to be signed in the presence of the Sponsor/AMIAS escort)

I _____ hereby grant permission to _____ to travel to and from
(Parent/Guardian Name) (Alateen member name)

and to participate in (2020 Salt City Midwinter Roundup) under the Supervision of:

_____ on _____
(Sponsor/AMIAS escort Name) (Dates of Event including Travel Time)

Parent/Guardian Signature: _____ Date: _____

FORM B: 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/AMIAS 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/AMIAS escort name) _____ has had allergic reaction from the following:

- (please check):
- Penicillin _____
 - Local Anesthetics _____
 - Aspirin _____
 - Sulphur Drugs _____
 - Sedatives _____
 - Bee Stings/Insect Bites _____
 - Pollens _____
 - 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.

(Alateen member or Sponsor/AMIAS escort name) _____ is currently using the following medications:

OTHER CONDITIONS OR PROBLEMS

(Alateen member or Sponsor/AMIAS escort name) _____ has the following condition or problems not listed above that you should know about: (please explain)

FORM B: MEDICAL FORM

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MEDICAL INSURANCE INFORMATION

You must provide medical insurance information in the space below.

For the US:

Name of Insurance Co. _____

Employer Name _____

Employee Name and Social Security Number _____

Group ID Number _____

(or attach a medical coupon if covered by Medicaid)

NOTARY STATEMENT

Form B, Authorization to Obtain Medical Care, is not valid without a signed and sealed Notary Statement

State/Province of _____

County of _____

(Sponsor/Escort/Responsible Party Name) _____ is 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 my (state relationship - self, son, daughter) _____.

Dated this _____ day of _____ (year) _____

(Signature - if 18 or over)

(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 acknowledged to me that (s)he executed the same for the purpose therein stated.

WITNESS my hand and seal this _____ day of _____ (year) _____

NOTARY PUBLIC: _____

My Commission Expires:

Seal: