FORM A: INFORMATION AND PERMISSION FORM

Since laws vary from Area to Area, it is suggested that this form be reviewed for compliance with local laws.

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.

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: _____

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)

FORM A: INFORMATION AND PERMISSION FORM

Since laws vary from Area to Area, it is suggested that this form be reviewed for compliance with local laws.

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 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:_____ Date: _____

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

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

from and to participate in_____under the supervision of
(Event Name)

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

Parent/Guardian Signature:_____ Date: _____

FORM B: MEDICAL FORM

Since laws vary from Area to Area, it is suggested that this form be reviewed for compliance with local laws.

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

Since laws vary from Area to Area, it is suggested that this form be reviewed for compliance with local laws.

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)

For Canada:

Health Card or Medi-Number _____

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

Dated this _____ day of _____ 20___

_____ (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_____20_____

NOTARY PUBLIC

My Commission Expires: Seal: