

**Alateen Information and Permission Form**

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

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

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

**SPONSOR/ADULT 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 (MINOR)**

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: (        )

WSO ID #

**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):

**CUSTODIAL PARENT/GUARDIAN INFORMATION**

First and Last Name:

Address:

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code:

Phone Number: Home (        ) \_\_\_\_\_ Work (        )

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

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

First and Last Name:

Address:

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code:

Phone Number: Home (        ) \_\_\_\_\_ Work (        )

**HOLD HARMLESS STATEMENT**

I am responsible for payment of any medical services required and obtained on the aforementioned Alateen member's behalf. I further hold harmless the event attended by my child, the Sponsor/Adult Escort, the group, district, Al-Anon Family Groups of Colorado Area Assembly, Inc. and all authorized representatives of the foregoing, and waive and release each of them from any and all liabilities, obligations, losses, damages, costs and expenses, causes of action, suits, claims, demands and judgments of any nature or description whatsoever including, without limit, claims for negligence in relation with the aforementioned Alateen member's participation in this activity or procurement of medical treatment.

Parent/Guardian Signature:

Date:

**PARENTAL PERMISSION** (to be signed in the presence of sponsor/escort)

I, \_\_\_\_\_ (Parent/Guardian name)

hereby grant permission for \_\_\_\_\_ (Minors Name)

to travel to and from and to participate in \_\_\_\_\_ (Event Name)

under the supervision of \_\_\_\_\_ (Sponsor/Escort Name)

beginning on \_\_\_\_/\_\_\_\_/\_\_\_\_ and ending on \_\_\_\_/\_\_\_\_/\_\_\_\_ (Dates of Event including Travel Time)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Appendix H: Alateen Authorization to Obtain Medical Care Form**

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

**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 First and Last Name) \_\_\_\_\_ has (had) the following diseases or problems:

(Please Check)

- 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 First and Last 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 First and Last Name) \_\_\_\_\_ is currently using the following medications:

**OTHER CONDITIONS OR PROBLEMS**

(Alateen First and Last Name) \_\_\_\_\_ has the following condition or problems not listed above that you should know about (please explain):

**MEDICAL INSURANCE INFORMATION**

You must provide medical insurance information in the space below:

For the US:

Name of Insurance Co:

Employer Name:

Employee SSN:

Group ID Number:

(or attach a medical coupon if covered by Medicaid)

**NOTARY STATEMENT**

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

\_\_\_\_\_ (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

\_\_\_\_\_ (Participants Name)

who is my \_\_\_\_\_ (state relationship – self, son, daughter)

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

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

\_\_\_\_\_  
(Signature of Parent or Guardian, if under 18)

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

\_\_\_\_\_)ss  
County of \_\_\_\_\_)

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by:

\_\_\_\_\_

Witness my hand and official seal:

\_\_\_\_\_

(Notary Public)

My Commission Expires: \_\_\_\_\_

(SEAL)