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)

For Canada:
Health Card or Medi-Number:

NOTARY STATEMENT

This form, 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 _____ year

_____ on
(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: