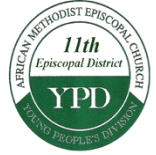




African Methodist Episcopal Church - Eleventh Episcopal District
 Young People's and Children's Division of the Women's Missionary Society
 Black Heritage Weekend
 February 14-16, 2020



MEDICAL AUTHORIZATION FORM

Name _____ Age _____ DOB: _____

Address _____

City, State and Zip Code _____

Home Phone # _____ Cell Phone # _____

Name of Parent(s) or legal guardian(s): _____

Address _____

City, State and Zip Code _____

Home Phone # _____ Cell Phone # _____

Alternate Contact _____

Home Phone _____ Cell Phone _____

I/We the above named parent(s) or legal guardian(s) do hereby appoint:

Name _____ Chaperone or Director

Home Phone _____ Cell Phone # _____ to act on my/our behalf in authorizing

medical or surgical care and hospitalization for the above name participant during the period which the participant will be under your supervision. This document shall be presented to a physician, or appropriate hospital representative, at such time as medical or surgical care or hospitalization may be required. Name of Participant's Physician _____ Phone # _____

Does the participant have, or at any time had, any of the following? _____ If YES, please explain and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, current medications, any specific activities to be restricted and other comments.

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Wear Glasses, Contact Lens	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Wear Hearing Aids	<input type="checkbox"/>
<input type="checkbox"/>	Ear Infection	<input type="checkbox"/>	Wear Pacemaker	<input type="checkbox"/>
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Other Conditions	<input type="checkbox"/>
<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	Drug or Other Allergies	<input type="checkbox"/>

 Parent(s) or Legal Guardian (s) Signature

NOTARY

On this _____ day of the month of _____, 20____, stood before me, as Notary Public of the County of _____ State of _____, acknowledging and submitting proof thereof as parent or guardian of _____, acknowledging execution of this affidavit.

Signature of Notary Public _____ My commission expires on: _____