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.

	Asthma			Headaches	
	Bronchitis			Hypoglycemia	
	Convulsions			Wear Glasses, Contact Lens	
	Diabetes			Wear Hearing Aids	
	Ear Infection			Wear Pacemaker	
	Fainting			Other Conditions	
	Heart Condition			Drug or Other Allergies	

_____
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: _____