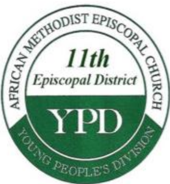
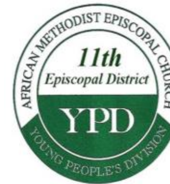


African Methodist Episcopal Church - Eleventh Episcopal District
Young People's and Children's Division of the Women's Missionary Society

Black Heritage Weekend

February 14-16, 2025



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			Bronchitis	
	Headaches			Hypoglycemia	
	Convulsions			Diabetes	
	Wear Glasses, Contact Lens			Wear Hearing Aids	
	Ear Infection			Fainting	
	Wear Pacemaker			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: __________