

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

PARENTS: 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**

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: (\_\_\_\_) \_\_\_\_\_

**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 whenever possible)

CUSTODIAL PARENT/GUARDIAN INFORMATION

First and Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

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

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

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

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

First, Last Name & Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

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

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

HOLD HARMLESS STATEMENT

As the parent/guardian of aforementioned Alateen member, I am responsible for payment of any medical services required and obtained on said member's behalf. I further hold harmless the event attended by my child and \_\_\_\_\_

(insert name and WSO registration number (if known) of group, district, Al-Anon Information Service office, and/or area) or authorized representative thereof, should any harm come to my child as a result of his/her participation in this activity or procurement of medical treatment.

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

**PARENTAL PERMISSION (to be signed in the presence of the Sponsor/Escort/Notary)**

I, \_\_\_\_\_ hereby grant permission to \_\_\_\_\_ to travel to

(Parent/Guardian Name)

(Alateen member name)

and from and to participate in \_\_\_\_\_

(Event Name)

under the supervision of \_\_\_\_\_

(Sponsor/Escort Name)

on \_\_\_\_\_

(Dates of Event including Travel Time)

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

# FORM B: MEDICAL FORM

## 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 member or Sponsor/escort name) \_\_\_\_\_ has  
(had) the following diseases or problems:

Heart Trouble _____	Epilepsy _____
Tuberculosis _____	Liver Trouble (Hepatitis) _____
Stomach Ulcers _____	Fainting spells or Seizures _____
Asthma _____	Diabetes _____
High Blood Pressure _____	Hives _____
Low Blood Pressure _____	

Other (Please describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES

(Alateen member or Sponsor/escort name) \_\_\_\_\_ has had allergic  
reaction from the following: (please check):

Penicillin _____	Sedatives _____
Local Anesthetics _____	Bee Stings/Insect Bites _____
Aspirin _____	Pollens _____
Sulphur Drugs _____	

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 members **MUST** give all medications to their Sponsor/Escort for the duration of the event.

(Alateen member or Sponsor/escort name) \_\_\_\_\_ is currently using the following  
medications: \_\_\_\_\_

### OTHER CONDITIONS OR PROBLEMS

(Alateen member or Sponsor/escort 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 Social Security Number \_\_\_\_\_

Group ID Number \_\_\_\_\_

(or attach a medical coupon if covered by Medicaid)

**For Canada:**

Health Card or Medi-Number \_\_\_\_\_

**NOTARY STATEMENT**

Form B, 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 a period of one year from this date on behalf of \_\_\_\_\_

(Participant's Name)

who is my \_\_\_\_\_. Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_  
(state relationship – self, son, daughter)

\_\_\_\_\_  
(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 \_\_\_\_\_ 20\_\_\_\_\_

NOTARY PUBLIC

My Commission Expires: Seal: