

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) _____

FORM B: MEDICAL FORM

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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 6 months 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: