AFG FLORIDA SOUTH AREA 10
TRAVEL AND MEDICAL RELEASE
Including Authorization And
Consent For Emergency Medical Treatment Of A Minor

Note: This form must be notarized; please complete both pages of the form

To be carried while traveling to and from any Alateen / Al- Anon Meeting /Event

I do hereby authorize _____ (full name of certified Al-Anon Member Involved In Alateen Service (AMIAS) who is the accompanying certified AMIAS to transport my child / ward named _____ _____ to the function described below and / or empower him / her to act as my agent, in case of emergency, to consent to any x-ray, examination, anesthetic, medical or surgical treatment and hospital care which is deemed advisable by, and is tendered under the general and special supervision of any physician and surgeon licensed to practice medicine in the State of Florida, whether such diagnosis or treatment is rendered at the office of said physician, urgent care center or medical center. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care that might be required and is given to provide authority and power to the aforementioned physician in the exercise of his or her best judgment that may be deemed advisable. Medical and insurance information is provided on the second page of this form. I understand that I retain full financial responsibility for any care rendered to my child / ward, and that the accompanying AMIAS has no financial responsibility for any emergency care rendered under this authorization.

Alateen's full name: _____Age: ___ Date of Birth (month, day, year):_____

Name of function / meeting: _____ Dates of function / meeting: _____

If authorization is for recurring events, list the dates up to one year for which authorization is given:

From (mo/year) _____to (mo/year) _____

What is the best way to contact you, the parent or Guardian, in an emergency? _____

Home phone: (_____)_____ Cell phone: (_____)_____

Other emergency contact if the parent or guardian cannot be reached:

Name _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____)_____

Parent or Legal Guardian (print name) _____

Parent or Legal Guardian (signature) _____

_____

Dated this _____day of _____ 201____ State of Florida

County of _____

Before me, the undersigned 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 he/she executed the same for the purpose therein stated.

WITNESS my hand and sealed this _____day of _____, 201_

NOTARY PUBLIC, State of Florida

My commission expires

TRAVEL AND MEDICAL RELEASE

GENERAL MEDICAL AND INSURANCE INFORMATION:

Alateen's full name: _____

Does the Alateen have any medical conditions / allergies to food, substances or medications? Yes____ No _____

If yes, please list below:

Acute or Chronic Medical Conditions: _____

_____

Allergies (include allergies to medications): _____

_____

Is the Alateen taking any prescribed or over the counter medicines? Yes _____ No _____

Please list any medication currently being taken, including the dosage (quantity and number of times each day). (Include medicines such as insulin, penicillin, local anesthetics, aspirin, sulfa drugs, sedatives, injectable medications)

Medication	Dosage	Frequency (How often each day, and specific times, if required.)

Is the Alateen covered by Medical / Accident Insurance? Yes _____ No _____

Insurance Company Name: _____

Name of Primary Insured (usually the parent) _____

Contact Number for Primary Insured: (_____) _____

Policy Number / Member Number _____

Insurance Company Phone Number to Call for Authorization: (_____) _____

Any other medical, insurance information or contact numbers not requested above: _____

_____

_____