

AFG FLORIDA SOUTH AREA 10

Parental Authorization Form Including Authorization and Consent for Emergency Medical Treatment of a Minor During Area 10 Conventions

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

Required for Any Alateen Attending Area 10 Conventions

I understand that I am responsible for the behavior, health, and welfare of my child / ward during the Convention and know that I will be contacted in the event of any emergency or dangerous situation involving my child / ward. However, in the event that I am unable to be contacted at the numbers I am providing below, I do hereby authorize and empower representatives of the AFG Florida South Area 10 to act as my agent, in case of emergency, to consent to any x-ray, examination, anesthetic, medical or surgical treatment and hospital care, or medication which is deemed advisable by and is tendered under the general and special supervision of any physician or 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. I understand 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 afore mentioned physician in the exercise of his or her best judgment that may be deemed advisable. Medical and insurance information must be provided as part of this form. I understand that I retain full financial responsibility for any care rendered to my child / ward, and that AFG Florida South Area 10 has no financial responsibility for any emergency care rendered under this authorization.

Alateen's full legal name: _____

Age: _____ Date of Birth: _____
(month, day, year)

Name of Function: _____

Dates of Function: From _____ to _____

EMERGENCY CONTACTS:

My name is (the custodial parent / legal guardian) _____

Where are you, the custodial parent / legal guardian staying? (hotel name or other address)

Location Name: _____ Room # _____

Other Address: _____

What is the best way to contact you, the custodial parent / legal guardian, in an emergency?

Cell phone: (_____) _____ Other phone: (_____) _____

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

Name: _____ Relationship: _____

Cell phone: (_____) _____ Other phone: (_____) _____

GENERAL MEDICAL INFORMATION: (Note this information will be kept confidential and only used in case of emergency. It will be shredded after the event.)

Alateen's legal name on insurance documents: _____

Does the Alateen have any acute or chronic medical conditions?

Yes

No

If yes, please explain below:

Does the Alateen have any allergies to food, substances, or medications?

Yes

No

If yes, please explain below:

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

Please list any prescribed or over the counter medications currently being taken, including dosage (quantity and number of times each day). Include medications such as insulin, antibiotics, local anesthetics, aspirin, sedatives, other injectable medications and over the counter medications. If additional space is needed, please attach a separate page.

Medication Name	Dosage	Frequency (how often each day, specific times, if required)

Does the Alateen have any emergent or non-emergent medication in his or her possession, such as an Epi-pen or inhaler?

Yes No If yes, please explain below:

Medication Name	Dosage	Frequency (how often each day, specific times, if required)

INSURANCE INFORMATION:

Is the Alateen covered by Medical / Accident insurance? Yes No

Insurance Company Name: _____

Name of Primary Insured (usually a parent) _____

Contact Number for Primary Insured: (_____) _____

Insurance Company Phone Number to call for authorization: (_____)_____

ADDITIONAL INFORMATION: Please add any other medical, insurance or contact information not requested above:

Custodial Parent or Legal Guardian (print name) _____

Custodial Parent or Legal Guardian (signature) _____

STATE OF FLORIDA

COUNTY OF _____

Sworn to (or affirmed) and subscribed before me by means of physical presence or online notarization.

This _____ of _____, 20_____, by _____
Day month year name of person making statement

Signature of Notary Public-State of Florida

(NOTARY SEAL)

Name of Notary Typed, Printed, or Stamped

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____