SOUTH FLORIDA 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 the front and back 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 Alateen sponsor/ volunteer) who is the accompanying certified Alateen sponsor / volunteer to transport my child / ward to the function described below and 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 reverse side of this form. I understand that I retain full financial responsibility for any care rendered to my child / ward, and that the accompanying sponsor has no financial responsibility for any emergency care rendered under this authorization.

Name of function / meeting: **Alateen Conference** 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) _____

Alateen's full name: _____Age: _____Birthdate:_____

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

_____

Home phone: (_____)_____ Beeper or cell phone: (_____)_____

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

Relationship: _____ Home Phone: _____

Beeper or Cell Phone: _____

Parent or Legal Guardian (print name) _____

Parent or Legal Guardian (signature) _____

Dated this _____day of _____ 200__, 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 _____, 200__.

NOTARY PUBLIC, State of Florida
My commission expires

TRAVEL AND MEDICAL RELEASE

GENERAL MEDICAL INFORMATION:

If the Alateen has any medical conditions / allergies to food, substances or medications, 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)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the Alateen covered by Medical / Accident Insurance? _____yes _____no

Insurance Company Name: _____

Name of Primary Insured (usually the parent) _____

Policy Number / Member Number _____

Insurance Company Phone Number to Call for Authorization: _____

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

_____