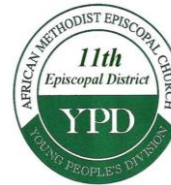


African Methodist Episcopal Church - Eleventh Episcopal District
 Young People's and Children's Division of the Women's Missionary Society



Black Heritage Weekend

February 16-18, 2024

MEDICAL AUTHORIZATION FORM

Name _____ Age _____ DOB: _____

Address _____

City, State and Zip Code _____

Home Phone # _____ Cell Phone # _____

Name of Parent(s) or legal guardian(s): _____

Address _____

City, State and Zip Code _____ Home Phone # _____

Cell Phone # _____ Alternate Contact _____

Home Phone _____ Cell Phone _____

I/We the above-named parent(s) or legal guardian(s) do hereby appoint:

Name _____ Chaperone or Director

Home Phone _____ Cell Phone # _____ to act on my/our behalf in

authorizing medical or surgical care and hospitalization for the above name participant during the period which the participant will be under your supervision. This document shall be presented to a physician, or appropriate hospital representative, at such time as medical or surgical care or hospitalization may be required.

Name of Participant's Physician _____ Phone # _____

Does the participant have, or at any time had, any of the following? _____ If YES, please explain and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, current medications, any specific activities to be restricted and other comments.

Asthma		Bronchitis	
Headaches		Hypoglycemia	
Convulsions		Diabetes	
Wear Glasses, Contact Lens		Wear Hearing Aids	
Ear Infection		Fainting	
Wear Pacemaker		Other Conditions	
Heart Condition		Drug or Other Allergies	

 Parent(s) or Legal Guardian (s) Signature

NOTARY On this _____ day of the month of _____, 20____, stood before me, as Notary Public of the County of _____ State of _____, acknowledging and submitting proof thereof as parent or guardian of _____, acknowledging execution of this affidavit.

Signature of Notary Public _____ My commission expires on: _____