

**Permission to Attend Al-Anon/Alateen Event  
Florida (N) - Area 9**

I \_\_\_\_\_, hereby grant permission for  
(Parent/Guardian's Name)  
\_\_\_\_\_, to travel to, and take part in  
(Alateen's Name)  
\_\_\_\_\_  
(Name of Event) (Location) (Date Information)

under the supervision of \_\_\_\_\_ or \_\_\_\_\_,  
(Name(s) Accompanying Adult(s) Involved in Alateen Service)  
who is in charge and will at all times make decisions for the best interests of all members of the group.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Alateen's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

County of \_\_\_\_\_ State of Florida

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 (s)he executed the same for the purpose therein stated.

**WITNESS** my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
Notary Public

\_\_\_\_\_  
Signature Seal:

Accompanying Adult(s) Involved in Alateen Service:

_____ (Print)	_____ (Print)
_____ (Sign)	_____ (Sign)
_____ (WSO ID#)	_____ (WSO ID#)

AUTHORIZATION TO OBTAIN MEDICAL CARE

I hereby authorize \_\_\_\_\_ or \_\_\_\_\_, accompanying Adult(s) Involved in Alateen Service, to obtain any medical care necessary for my child (or me) while traveling to and from, and for the duration of \_\_\_\_\_.  
(Event)

1. Do you have Medical or Accident Insurance? Yes No

If yes, name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

2. Does child (or you) have any of the following diseases or problems?

Please circle those that apply:

Heart Trouble	Low Blood Pressure	Seizures
Asthma	Fainting Spells	Liver Problems
Diabetes	Hives	Hepatitis
High Blood Pressure	Tuberculosis	Other _____

3. Is child (or are you) allergic to any medications? Please circle those that apply:

Penicillin	Sulphur Drugs	Local Anesthetics
Aspirin	Sedatives	Other _____

4. Does child (or you) have an allergy to any foods, pollens, stings etc? Yes No

If yes, please explain \_\_\_\_\_

Note: If child (or you) currently takes any medication, the accompanying Adult(s) Involved in Alateen Service should be made aware of this, as should the nurse at the event child (or you) attends.

I further hold harmless above noted Adult Involved in Alateen Service, as well as the event attended by my child (or me) should any harm come to my child (or me) as the result of participation in this activity or procurement of medical treatment.

\_\_\_\_\_  
Parent/Guardian Signature (if under 18)      or      Signature (if over 18 years of age)

\_\_\_\_\_  
Print Name      Date \_\_\_\_\_

County of \_\_\_\_\_ State of Florida

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 (s)he executed the same for the purpose therein stated.

**WITNESS** my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public

\_\_\_\_\_  
Signature

Seal: