Southern California Conference Young People's and Children's Division of the Women's Missionary Society African Methodist Episcopal Church
YPD Medical Authorization

NAME _____Age: ___ Birth Date: _____
(Please Print)

ADDRESS: _____

CITY: _____ Zip _____

Phone: (_____) _____ Sex: ____ Male ____ Female

I/We, the undersigned parent(s)/guardian(s) of _____ a minor, do hereby give my/our consent to the appointed chaperons for the Southern California Conference YPD to authorize any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and rendered under the supervision of a licensed hospital or medical office. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care, but is given to provide authority for the chaperons to give consent to any medical treatment as deemed necessary.

HEALTH HISTORY: (check appropriate data)

Ear Infections	____	Insect Sting Bites	_____	German Measles	_____
Convulsions	____	Hay Fever	_____	Chicken Pox	_____
Diabetes	____	Penicillin	_____	Measles	_____
Asthma	____	Other Medications (specify) _____	_____	Mumps	_____

Any known allergies (food, animals, etc.)? _____

Is your child currently on medication? Yes ( ) No ( ) If yes, please specify _____

_____

The name of medical care provider: _____

Medical number or policy number: _____

This authorization will be effective only during the period of _____ to _____.

Parent/Guardian Name: _____ Phone: ( ) _____
(please print)

Signature _____ Date: _____
(This form must be signed by parent/guardian if participant is under the age of 26 years)

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PERSON OTHER THAN PARENT TO BE NOTIFIED IN AN EMERGENCY SITUATION WHEN PARENT(S) ARE NOT AVAILABLE

_____
Name Relationship Home Phone Emergency Phone