



**A.E.A.O.N.M.S., INC.
IMPERIAL YOUTH DEPARTMENT**

PERMISSION TO PARTICIPATE IN SPECIAL ACTIVITY

Date: _____

Dear Administrator: _____

My Son/Daughter _____ in the Youth Group has my

(Child's Name)

permission to go on a field trip to _____

(Place of Activity)

_____ on _____

(Mode of Transportation)

(Date)

I will accept full responsibility for my child, both to and from, and while engaged in the above activity.

Special Instructions: _____

APPROVED: _____

DIRECTOR/DIRECTRESS

PARENT SIGNATURE

ADMINISTRATOR

DATE

EMERGENCY TELEPHONE NUMBER

CONTACT PERSON NAME

PROGRESS WITH PRIDE – UNITED IN SERVICE

**Mail To: AEAONMS and PP John Buckley, Jr.,
Attn.: Youth Department Director
2239 Democrat Road
MEMPHIS, TN 38132-1802**

DEADLINE: JUNE 24, 2022

(PLEASE PRINT OR TYPE)

Name of Youth Group

Youth Name _____ Birth Date _____ Sex _____

City/State of _____ Temple/Court _____ Convention City Hotel _____

Youth's Address _____

Parent(s)/Guardian Name _____

Address (If different than student) _____

_____ Home Phone No. () _____

Family Physician's Name _____

Address _____ Phone No. () _____

Primary Insurance Company _____ Policy # _____

Insured Name _____

Address to Send Claim _____

MEDICAL HISTORY

Yes No

- 1. Has this youth ever had Hospitalization, Surgery, Injury, or Serious Medical Illness?.....
- 2. Is this youth now under the care of a physician or taking any medication?.....
- 3. Has any physician ever recommended, or do you feel that there should be limits placed on participation in competitive sports?.....
- 4. Does this youth have any known allergies to medications?.....
- 5. Does this youth wear glasses or contact lenses? Give date of last exam, if "Yes".....
- 6. Has this youth ever blacked out or lost consciousness during physical activity?.....

If Yes, Please Specify:

We consent to the participation of the above-named youth in the A.E.A.O.N.M.S. program of His/Her youth group, including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by the physicians designated by the proper authorities.

Youth _____ Parent/Guardian _____ Date _____

• HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO THE PHYSICAL EXAMINATION •

HEALTH EXAMINATION

Optional Tests —

Youth's Name _____ Age _____

Height _____ Weight _____ BP _____ Pulse _____

Abnormal physical findings:

Urinalysis:
Albumin:
Sugar:
Micro (if above test abnormal):
Blood Count:
(For Females)
HGB:

Should there be any limitations placed on athletic participation?..... Yes _____ No _____

Recommendations:

I certify that I have on this date examined this youth and the basis of the examination required by the organization and the youth's medical history as furnished to me. I have found no reason which would make it medically inadvisable for this youth to compete in supervised athletic activities. (NOTE EXCEPTIONS ABOVE.)

PHYSICIAN'S NAME AND ADDRESS (STAMP OR PRINT)

PHYSICIAN'S SIGNATURE _____ (M.D. or D.O.)

PHYSICIAN'S TELEPHONE NO. _____ DATE _____