Arkansas Area 02
Medical Form
Required for Overnight Travel
(Complete this form and give it to your AMIAS/escort)

AUTHORIZATION TO OBTAIN MEDICAL CARE

(This form is required in the event that medical care become necessary while this child is traveling.)
In order for anyone to obtain medical care for another person who is not a family member, this form must be filled out entirely and bear the original notary seal.

When distance and time may compromise acquisition of timely medical attention, attendance to a fellowship event can be prohibited if this form is not properly filled out and notarized.

DISEASES/MEDICAL CONDITIONS

(Traveling Child's Name) _____ has (had) the following diseases or problems:

- ☐ Heart Trouble
- ☐ Epilepsy
- ☐ Liver Trouble (Hepatitis)
- ☐ Diabetes
- ☐ Fainting Spells or Seizures
- ☐ Stomach Ulcers
- ☐ Hives
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Fainting Spells or Seizures
- ☐ Liver Trouble (Hepatitis)
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Other (Please describe) _____

ALLERGIES

(Traveling Child's Name) _____ has (had) the following diseases or problems:

- ☐ Penicillin
- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Pollens
- ☐ Sulfur Drugs
- ☐ Sedatives
- ☐ Bee Stings/Insect Bites
- ☐ Foods (please list) _____
- ☐ OTHER (please specify) _____

Has he/she had a Tetanus Shot? _____ Date of last Tetanus Shot_____

CURRENT MEDICATIONS

Please list all prescriptions & over-the-counter drugs (i.e. Tylenol, aspirin, antacids, antihistamines…). **These medications MUST be in their original container(s) with labels firmly in place.**
(Traveling Child's Name) _____ is currently using the following medications: _____
_____

OTHER CONDITIONS OR PROBLEMS

(Traveling Child's Name) _____ has the following condition or problems not listed above that you should know about (please explain)

_____
_____
_____
_____

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MEDICAL INSURANCE INFORMATION

You must provide medical insurance information in the space below.

Name of Insurance Company:

_____

Employer Name:

_____

Employee Social Security Number:

_____

Policy and/or Group ID Number:

_____

(Or attach a medical coupon if covered by Medicaid)

NOTARY STATEMENT

Authorization to Obtain Medical Care is not valid without a signed and sealed Notary Statement.

(AMIAS/Escort/Responsible Party Name) _____

is authorized upon my signature below to obtain any medical care necessary for the duration of

_____

on behalf of (Participant's Name) _____,

Date of Birth _____, who is my _____
(relationship - self, son, daughter, etc…)

Dated this _____ day of _____ 20 ___

_____
(Signature – if 18 or over)(Signature of Parent or Guardian, if under 18)

Address _____

City _____ State _____ Zip/Postal Code _____

State of Arkansas

County of _____

Before me, the above signed 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

My Commission Expires: _____ Seal: _____