

**Military Order of the World Wars**  
**Arizona Youth Leadership Conference**  
**Phoenix, Arizona**

**PART I PARENTAL AUTHORIZATION AND RELEASE**

**PART II PARENTAL AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR**

**PART III MEDICAL HISTORY OF STUDENT**

**PLEASE PRINT OR TYPE ALL DATA**

Date: \_\_\_\_\_

We, or I, the undersigned being the natural parent(s) or the designated legal guardian(s) of \_\_\_\_\_ Age \_\_\_ Date of Birth-MO. \_\_\_ Day \_\_\_ Year \_\_\_, authorize his/her attendance at the Military Order of the World Wars (MOWW) Arizona Youth Leadership Conference (AZYLC) to be conducted at ASU West, Phoenix, AZ during the period from **16-20 July 2013**. The \_\_\_\_\_ Chapter of the MOWW is the designated sponsor and will provide expenses for the student's transportation, tuition, room and board.

**PART I AUTHORIZATION AND RELEASE**

In consideration of the payment of the conference fee, the undersigned hereby release and contract to hold harmless the MOWW, the AZYLC and the \_\_\_\_\_ Chapter of the MOWW from any and all liability and/or responsibility for the student's welfare, well being, and control for the period of the conference (including the day of departure if the chapter provides transportation until the day of return).

**PART II PARENTAL AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR**

Health Insurance Company \_\_\_\_\_ Family Doctor \_\_\_\_\_

Insurance Policy No. \_\_\_\_\_ Doctor's Phone No. (\_\_\_\_) \_\_\_\_\_

I/we the undersigned parent/guardian of the above named student, do hereby authorized the Director of the MOWW-AZYLC or his designated staff member, as agent for the undersigned, to consent to any x-ray, examination, surgical diagnosis, treatment and hospital care which is deemed advisable by, and which is under the general or specific supervision of any physician or surgeon licensed under the Medical Practice Act.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent to provide care, which the aforementioned physician, in the exercise of his best judgment may deem advisable.

This authorization will be in effect for the duration of the conference unless sooner revoked in writing and delivered to the Director of AZYLC.

**PART III MEDICAL HISTORY**

Date of last complete physical examination: \_\_\_\_\_

Has it ever been necessary to restrict the student's physical activities for medical reasons?

If yes, explain: \_\_\_\_\_

Is the student now under medical care or regularly taking any medication? \_\_\_\_\_

If **YES**, explain and list **ALL** medications: \_\_\_\_\_

\_\_\_\_\_

Has there been any significant surgery, injury, illness or change in the student's health status since last physical? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Date of Immunizations: Tetanus: \_\_\_\_\_, Diphtheria: \_\_\_\_\_, Polio: \_\_\_\_\_

Measles: \_\_\_\_\_, Influenza: \_\_\_\_\_, Pertussis: \_\_\_\_\_, Other \_\_\_\_\_.

**EMERGENCY MEDICAL INFORMATION (\*Emergency Telephone # mandatory)**

**IF SUBJECT TO ANY OF THE FOLLOWING, PLEASE CHECK AND EXPLAIN**

\_\_\_\_\_ Allergy to any plant, food or animal: \_\_\_\_\_

\_\_\_\_\_ Allergy to any drug or insect toxin: \_\_\_\_\_

\_\_\_\_\_ Any condition requiring regular medication or diet or special care: \_\_\_\_\_

\_\_\_\_\_ Asthma: \_\_\_\_\_ Convulsions: \_\_\_\_\_ Heart: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Other (explain): \_\_\_\_\_

The information contained on these medical reports will be handled with extreme care and will only be used by authorized AZYLC or medical personnel.

By our signatures hereto we fully understand that we waive any and all rights whatsoever and agree not to exercise any right to make claim or to litigate against the organization listed above, in the name of the Military Order of the World Wars.

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

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

**Telephone\*** \_\_\_\_\_

-----  
**State of** \_\_\_\_\_ **County of** \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 2013 before me the undersigned Notary Public, personally appeared \_\_\_\_\_ known to me to be the person(s) whose name(s) is/are subscribed to the foregoing document and acknowledge that he or she executed the same for the purposes therein contained.

Witness my hand and official seal: \_\_\_\_\_

My commission expires: \_\_\_\_\_

-----  
Approved: MOWW Chapter \_\_\_\_\_

By: \_\_\_\_\_

Name

Title

Date

**TO BE COMPLETED BY AZYLC PERSONNEL**

\_\_\_\_\_  
Designated AZYLC Medical Person

\_\_\_\_\_  
AZYLC Director