



# AZYLC

## Consent Form



Sponsored by the Military Order of the World Wars, Inc.

This is a four-part form consisting of:

- Part I: Parental Authorization & Release
- Part II: Parental Authorization to Consent to Medical Treatment of a Minor
- Part III: Delegate Medical History
- Part IV: Photo Release

**PLEASE COMPLETE ALL THE SECTIONS OF THIS FORM PACKAGE**

Date: \_\_\_\_\_  
DAY / MONTH / YEAR

Name: \_\_\_\_\_  
FIRST NAME / MIDDLE INITIAL / LAST NAME

Age: \_\_\_\_\_  
ON 30 JUNE 2024

Date of Birth: \_\_\_\_\_  
DAY / MONTH / YEAR

Chapter Sponsor:  PHOENIX  SANTA CRUZ VALLEY  WEST VALLEY

We/I, the undersigned being the natural parent(s) or the designated legal guardian(s) of the delegate applicant listed herein authorize his/her participation at the Military Order of the World Wars, Inc. (MOWW) Arizona Youth Leadership Conference (AZYLC) program to be conducted at \_\_\_\_\_ during the period from \_\_\_\_\_ to \_\_\_\_\_. The sponsoring MOWW chapter listed herein will provide expenses for the delegate applicant transportation, tuition, room, and board.

### **PART I: AUTHORIZATION & RELEASE**

In consideration of the payment of the conference fee the undersigned hereby releases and contract to hold harmless the MOWW, the AZYLC, and the sponsoring MOWW chapter from any, and all liability, and/or responsibility for delegate applicant 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 Provider:

---

Health Insurance Policy #::

---

Family Doctor: :

---

Doctor's Phone #: (     ) \_\_\_\_\_

I/we the undersigned parent/guardian of the delegate do hereby authorize the AZYLC Executive Director or their 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 physician, in the exercise of his best judgment, may deem advisable.

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

**PART III: MEDICAL HISTORY**

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

Has it ever been necessary to restrict the delegate's physical activities for medical reasons? If **yes**, please explain:

---

---

---

Is the delegate now under medical care or regularly taking any medication(s)? If **yes**, explain and list **ALL** medications:

---

---

---

---

Has there been any significant surgery, injury, illness or change in the delegate's health status since last physical? If **yes**, please explain:

---

---

***Please certify that the delegate is free of head lice.*** In cases where head lice are found, the AZYLC Executive Director will inform affected students, their parents, and the school contact. Parents/guardians must return the delegate home immediately, if notified that head lice are found.

Dates of Immunizations are **Critical**: Tetanus: \_\_\_\_\_ Diphtheria: \_\_\_\_\_ Polio: \_\_\_\_\_  
Measles: \_\_\_\_\_ Influenza: \_\_\_\_\_ Pertussis: \_\_\_\_\_ Other: \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION \*Emergency Phone # is 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 (please explain):

---

---

The information contained in this medical history will be handled with extreme care and will be used only by authorized AZYLC or medical personnel in the care of the delegate.

**PART IV: PHOTO RELEASE**

I/we the undersigned parent/guardian of the delegate hereby grant to AZYLC and MOWW the right to reproduce, use, exhibit, display, broadcast, distribute and create derivative works of related photographs or videos for use in connection with the activities of the AZYLC or for promoting, publicity use or advertising the conference program or its activities. This grant includes, without limitation, the right to publish such images in any of the wide variety of formats and media available, including, but not limited to, print, and electronic/online/social media.

By the 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, Inc.

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

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

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

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

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

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

\_\_\_\_\_

\_\_\_\_\_

\*Phone #: \_\_\_\_\_

\*Phone #: \_\_\_\_\_

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

By: \_\_\_\_\_  
TITLE / FIRST NAME / MIDDLE INITIAL / LAST NAME DATE: DAY / MONTH / YEAR

-----  
TO BE COMPLETED BY AZYLC ASSISTANT DIRECTOR OF ADMINISTRATION & PERSONNEL

\_\_\_\_\_  
Designated AZYLC Medical Staff

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