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 permission to go on a field trip to** _____

(Child's Name)

(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. In an effort to promote the Imperial Youth Department educational programs and mentoring activities, I approve for my child to be included on the Imperial youth website and promotional material.

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 Rev. Ronald E. Williams, Sr.
Attn.: Youth Department Director
2239 Democrat Road
MEMPHIS, TN 38132-1802

DEADLINE: JUNE 14, 2019

A.E.A.O.N.M.S., INC.
IMPERIAL YOUTH DEPARTMENT
PARTICIPATION & PHYSICAL EXAMINATION FORM

(PLEASE PRINT OR TYPE)

Name of Youth Group

Youth Name _____ (Last) _____ (First) _____ (Middle) Birth Date_____ Sex____

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

Youth's Address _____

Parent(s)/Guardian Name _____

Address (If different than student)_____ (Street) _____ (City) _____ (ZIP)

_____ (City) _____ (ZIP) 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

Youth's Name _____ Age_____

Height_____ Weight_____ BP_____ Pulse_____

Abnormal physical findings:

Optional Tests —

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_____

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