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

YOUTH PARTICIPATION FORM

☐ Non-member Youth ☐ Youth Club Member

Date _____ Convention City _____ Convention Year _____

Temple/Court Name & No. _____ Temple/Court City & State _____

Youth's Name _____ Date of Birth _____ ☐ Male ☐ Female

Youth Street Address _____ City _____ State _____ Zip _____

Parent(s)/ Guardian Name _____ Phone # _____ Alternate Phone: _____

Emergency Contact Name _____ Phone # _____

Family Physician _____ Phone # _____ Dentist Name _____ Phone # _____

MEDICAL HISTORY

1.	Has this youth ever had hospitalizations, injury, or serious medical illness? (asthma, headaches, nosebleeds, etc.)?	☐ Yes	☐ No
2.	Is this youth now under the care of a physician or taking any medication?	☐ Yes	☐ No
3.	Has any physician ever recommended, or do you feel that there should be limits placed on participation in competitive sports?	☐ Yes	☐ No
4.	Does this youth have any known allergies to medication?	☐ Yes	☐ No
5.	Does this youth wear braces, glasses or contact lenses?	☐ Yes	☐ No
6.	Has this youth ever blacked out or lost consciousness during physical activity?	☐ Yes	☐ No
7.	Does the child have any type of disabilities or allergies?	☐ Yes	☐ No
8.	Has the child been treated for any of the following: Bleeding, Convulsions, Diabetes, Epilepsy, Heart Trouble, Kidney, Lung Disease, Muscle Joint, Other?	☐ Yes	☐ No

If Yes to any of the above, please specify: _____

Note: Please remember to pack all your youth current medications and notify your Director/Directress.

PHOTO RELEASE

☐ I/We grant the Youth Club/Conference agents/staff or affiliates the right to take photographs of my child. I agree that the aforementioned may use such photographs of my child for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media, and website content.

☐ I/We do not grant the Youth Club/Conference agents/staff or affiliates the right to take photographs of my child.

CONSENT

I/we consent to the participation of the above-named youth in the activities and conferences of His/Her youth group, including practice sessions, and travel to and from conferences, athletic events, and other program activities. I also agree to emergency medical treatment as deemed necessary by the physicians designated by the proper authorities. I will accept full responsibility for my child, both to and from, and while engaged in their activities.

_____ _____ _____

Youth Name Parent/Guardian Signature Date

*****Note: Physical exams may be required for any strenuous activities that youth will be participating in.**

☐ **Check this box if you decide to forego a physical examination for your youth.**

****Note: If you have a current physical exam for your youth, it is acceptable. Attach to this form and submit.**

MEDICAL HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO THE PHYSICAL EXAMINATION.

--PHYSICAL EXAMINATION--

Youth Name _____ Age: _____ Height: _____ Weight: _____ BP: _____ Pulse: _____

Urinalysis: _____ Albumin: _____ Sugar: _____ Micro (If the test was abnormal): _____

Blood Count (for Females): _____ HGB: _____

Abnormal physical findings: _____

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 DD.): _____

PHYSICIAN'S PHONE NO. _____ Date _____

Rv: 09142024

MAIL TO: HPIC Lorraine James
Youth Dept Director
Po Box 6424
Tallahassee, FL 32314