



# IT'S TIKI TIME AT ALATEEN

Mask required (will observe safety guidelines)

**Saturday, May 15, 2021**

**Covered Bridge Park**

**229 Keeley Ave, New Britain, PA 18901**

**Schedule:**

***Welcome & meeting 3-4***

***Free time/games/fellowship/fishing 4-6***

***Dinner 6-7***

***7-8 Prizes, Raffle & 50/50***

***8-9 Sharing around the fire***

***Please bring snacks to share & desserts***

***Groups are asked to donate raffle items***

\$5 donation ~ if you can't pay, don't stay away!

## PA AREA ALATEEN

### Permission Form / Medical Information

I hereby grant permission for \_\_\_\_\_, age \_\_\_\_\_, who is/is not a minor (circle one) with a Date of Birth of: \_\_\_\_/\_\_\_\_/\_\_\_\_, to take part in Alateen picnic – "It's Tiki Time in Alateen". I agree to hold the PA AWSC harmless for any or all occurrences that might occur while by son/daughter attends this event.

I agree that \_\_\_\_\_ (AMIAS) is in charge and will at all times make decisions in the best interest of my child. In case of accident or the need of emergency medical attention, the person designated above has my permission to use his/her best judgment. I hereby authorize the person designated above to obtain any emergency medical care necessary for my son/daughter at any licensed medical location during the event listed. It is understood that this information is given in advance of any specific diagnosis, treatment or hospital care that might be required and is given to provide authority and power to the licensed medical professional in the exercise of his/her best judgment in an emergency for my child in my absence.

**(Parent/Guardian) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone/Emergency Phone: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_

Doctor's Office Phone Number: \_\_\_\_\_

**My son/daughter has the following condition:**

\_\_\_\_\_

\_\_\_\_\_

**He/She is allergic to the following:**

\_\_\_\_\_

\_\_\_\_\_

**He/She requires the following medication** (including dosage, amount and time to be taken) which will be given by the sponsor/adult in charge of your child and group. Medication must be contained within the original prescription container(s)

\_\_\_\_\_

**Any other important information**, such as dietary needs:

\_\_\_\_\_

**Please bring the completed form and give to the AMIAS.**

**Sponsor Approval Signature:** \_\_\_\_\_

