G. O.Y.A. HEALTH PERMISSION FORM

Please complete the following form and return it to your Advisor.

GOYAN'S NAME _____

DATE OF BIRTH _____

ADDRESS _____

TOWN _____ STATE _____ ZIP _____

MOTHER'S NAME _____ PLACE OF EMPLOYMENT _____ TEL# _____

FATHER'S NAME _____ PLACE OF EMPLOYMENT _____ TEL # _____

FAMILY DOCTOR'S NAME _____ TEL# _____

HOSPITAL OF CHOICE _____

DENTIST'S NAME _____ TEL# _____

Are there any medical problems of which we should be aware? _____

Is your child taking either prescription or over-the counter medication on a regular basis? _____

	Yes	No	Name of Drug(s) _____
Drug Allergy?	Yes	No	Name of Drug(s) _____
Other Allergies?	Yes	No	Types: _____

Type of Reaction (be specific) _____

Name of Drugs _____

Names and telephone numbers of two persons to contact if your child is ill or injured. In the event that the parent or guardian cannot be contacted, these persons might have to make a medical decision.

1.Name _____ Telephone _____

2.Name _____ Telephone _____

EMERGENCY MEDICAL TREATMENT

To the Advisors and Reverend:

In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL. TREATMENT during any time he/she is a member of the G.O.Y.A., you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay for any professional medical services incurred.

Date _____ Parent/Guardian Signature _____

Permission for emergency medical treatment will be effective throughout the member's enrollment. If there is any change of information, please telephone the Reverend or Advisors.

YOUR INSURANCE COMPANY _____

TELEPHONE # _____

GROUP IDENTIFICATION #: _____ MEMBER # _____

DATE OF BIRTH OF MEMBER _____/_____/_____ (Mother or Father)

01/19/2006