PARENT PERMISSION AND MEDICAL TREATMENT CONSENT FOR MINORS

This form will enable your child to participate in out-of-center activities. It is our policy to contact parents in case of an emergency and the information contained on this form will help us to reach you quickly. The medical authorization will prevent delay of treatment for you child in the event that you cannot be reached in an emergency. We use the emergency facilities of Theda Clark Regional Medical Center or the nearest emergency facility for out-of-center activities.

Masks are required while riding in the van and while at the center. Community Service Club will meet for outdoor volunteer opportunities only. If bad weather arises, CSC will be cancelled that day.

YOUTH GO CELL PHONE: (920)-939-4330

Name of Activity: **Community Service Club** Date: **Wednesdays April 2021 – September 2021**

Leave Youth Go at: **IN PERSON SCHOOL DAYS AND VIRTUAL SCHOOL DAYS: You will meet Angie at Youth Go at 3:30pm**

Return to Youth Go at **5:30pm**

Location of Activity: **Community Service Club volunteers at various locations throughout the Fox Valley. Please sign up with Angie at Youth Go! angie@youthgo.com or (920)-722-1435**

Items to bring: **Comfortable close toed shoes, a Youth Go shirt or appropriate shirt, and a positive attitude!**

Rules: No use of alcohol or other drugs, no violence or threats of violence, and no leaving the group without permission from adult staff

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Detach and return to Youth Go

***I give my permission for _____ to participate in the program outlined above. I will not hold Youth-Go, Inc., staff members or any of its representatives liable for any accident or injury. I understand that if my son/daughter violates any of the rules outlined above, I will be informed and expected to make any arrangements necessary for his/her immediate return home.

Special health problems:_____

Insurance Company _____Policy #_____

Family Physician_____Phone_____

If a parent cannot be reached, contact:
Name_____Phone_____

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child.

_____
(Name of Child)

In the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician's office.

_____ _____ _____
Date Signature of Parent or Guardian Home Phone Number

_____
Work Phone Number