



PARENT PERMISSION FOR TRANSPORTATION AND MEDICAL TREATMENT CONSENT FOR MINORS

This form will enable your child to participate in the out-of-center activities described below. 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 your 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-town activities.

Name of Activity: **Community Service Club**      Date: **Wednesdays, September 2026 – June 2027**

Location: **YouthGo and transportation to various locations in the Fox Valley**

Leave YouthGo at: **approximately 4pm**

Return to YouthGo at: **Between 5:30pm – 6pm**

Items to bring: **Closed toed shoes, pants, weather appropriate clothing, positive attitude!**

Contact Charlie via email [charlie@youthgo.org](mailto:charlie@youthgo.org) or call (920)722-1435

**Rules: Follow the code of conduct for the event. No leaving the group without permission from the staff member(s) present. No violence or threats of violence. No use of alcohol or other drugs.**

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**Detach and return to Youth Go**

\*\*\*I give my permission for \_\_\_\_\_ to participate in the program outlined above, and receive transportation through Youth Go. 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 child violates any of the rules outlined above, I will be informed and expected to make any arrangements necessary for their immediate return home.

Special health problems: \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy #'s \_\_\_\_\_

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