



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.

YOUTH GO (920)-722-1435 CELL PHONE: (920)-939-4330 Email: angie@youthgo.org

Name of Activity: **Community Service Club** Date: **June 2022 – August 2022**

Leave Youth Go at: **3:15pm (unless otherwise stated)**

Return to Youth Go at: **6:00pm (unless otherwise stated)**

Location of Activity: **Sign up with Angie on the sign-up sheet at Youth Go!**

Items to bring: **Closed toed shoes, pants, Youth Go and weather appropriate clothing, 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

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