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.

June Field Trips

-**Baseball @ T-Rats Stadium** in Appleton, WI June 9, 2022 **Actual Cost: $12 **You Pay: $5**
Leave Youth Go @ 6pm and return @ 10:30pm (we will drop youth off at home)

-**EAA Museum** in Oshkosh, WI June 23, 2022 **Actual Cost: $10 **You Pay: $5**
Leave Youth Go @ 9:30am and return @ 3:30pm

-Mt. Olympus in Wisconsin Dells, WI June 30, 2022 **Actual Cost: $28 **You Pay: $15**
Leave Youth Go @ 10am and return @ 9pm

Actual cost is the combination of admission, lunch, and transportation (bus/van rental and fuel cost) prices
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

_____ _____
Parent/Guardian Name (Printed) Work Phone Number

>Please check the field trip(s) your child is going to attend<
___Baseball Game ___EAA Museum ___Mt. Olympus