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: **SEED Career Exploration** Date: **Summer 2023**
Leave Youth Go at: **Varies - Mondays** Return Approximately: **Varies - Mondays**
Location of Activity: **Throughout the Fox Cities Maybe Farther..** Cost: **No Cost**
Items to bring: **Dress "Business Casual" unless told otherwise.**
***** No Jeans/Leggings, flip flops etc…**
If in doubt, Please ask, or if you have any further questions contact Danielle.
Rules: 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

Detach and return to Danielle at Youth Go For SEED

***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 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 #'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
_____
Work Phone Number

Address for pickups: _____
_____

Cell phone number of Youth to text/call for reminder: _____