



**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.

Name of Activity: **Community Service Club** Date: **September 4<sup>th</sup>, 2024 – June 4<sup>th</sup>, 2025**

Leave Youth Go at: **Meet Angie at Youth Go after school (approximately 4pm) or on location at approximately 4:30pm (depending on location)**

Return to Youth Go at: **between 5:30pm and 6:00pm**

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!**

**Contact Angie via phone (920)-722-1435 or email: [angie@youthgo.org](mailto:angie@youthgo.org)**

**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 & Work Phone Number