



PARENT PERMISSION FOR TRANSPORTATION AND MEDICAL TREATMENT CONSENT FOR MINORS (to be completed by parent)

This form will enable your child to participate in out-of-center activities and transportation services. 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.

Youth Go Transportation Permission Slip.

Your child has expressed interest in attending Youth Go. We are open for youth entering 5th-8th grades Mondays and Wednesdays 3:00pm-5:30pm and Fridays from 3:00pm-8:00pm. We are open for youth entering 7th-12th grades Monday-Thursday 6:00pm-10:00pm and Fridays from 3:00pm-8:00pm. Programming consists of structured activities such as arts and crafts and games, or use center recreation equipment such as computers, video games, and pool tables. Youth will be supervised by professional adult youth workers.

Vans pick up at

*Maplewood, Horace Mann and Shattuck on Mondays, Wednesdays, and Fridays on regular school days and transport youth to Youth Go. Vans will wait in the bus loading area immediately after school.

*NHS after school on Thursdays by the rocket and transport youth to Youth Go for tutoring.

If Youth Go is closed due to inclement weather or a holiday, the vans will not be running.

Please feel free to contact Youth Go staff at (920) 722-1435 with any questions or concerns..

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 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 _____