Hope House Youth Center
1011 Pennsylvania Ave. | Windsor, IL 61957
PARENTAL PERMISSION AND MEDICAL AUTHORIZATION FORM

Participant Name: _____ Birth date: _____

I give permission for my child (named above) to attend the events, field trips, and service projects associated with Hope House Youth Center (Windsor, IL). I further give permission for my child to be transported to and from events by hired and volunteer drivers authorized by Hope House Youth Center.

Medical Release

I hereby authorize the Youth Group leaders, volunteers, Hope House Youth Center, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

Custody Release

I further authorize the Youth Group leaders of Hope House Youth Center (Windsor, IL) to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

Social and Advertising Release

You have received this parental consent form to both inform you and to request your permission for your child's photo/image and name to be published on hopehouseofwindsor.org and/or any other websites maintained, owned, and/or administrated ("Future Community Leaders Inc. NFP") by Hope House of Windsor. The law requires that we ask for your permission to use information about your child. Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes youth names, age, grade, and photo or image. If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to Hope House Youth Center, and such rescission will take effect upon receipt.

Initial one of the following choices:

_____ I/We GRANT permission for this youth's photo/image and all other personal identifiers listed above to be published on the Hope House Youth Center public website or any site operated by Hope House.

_____ I/We DO NOT GRANT permission for photo/image that includes this youth to be published on the Hope House Youth Center public website or any site operated by Hope House.

Activity Release

I further give permission for my child to participate in all activities sponsored by the Hope House Youth Center, except as noted:

_____

_____	_____	_____
Signature of Parent or Legal Guardian	**Printed Name of Parent or Guardian**	**Date**

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian(s)

Phone Numbers	Phone Type (Home, Mobile, etc.)

Name(s)

Street Address

City State Zip

Parent(s)/Guardian(s) Email address(es)

Email address(es)

Other Emergency Contact(s)

Phone Numbers	Phone Type (Home, Mobile, etc.)

Name(s) Relationship to Participant

HEALTH CARE INFORMATION

Participant Name: _____ Birth date: _____

Physician	**Dentist**
Name	Name
Phone	Phone
Medical Insurance Company	Dental Insurance Company
Policy/Group Number	Policy/Group Number
Name of Policy Holder	Name of Policy Holder

Please list any allergies to drugs, foods, plants, insects, etc:

Does your child wear glasses or contacts? ☐ Yes ☐ No

Date of last tetanus shot _____

For your child's safety and our knowledge, is your child a good, fair, or non-swimmer? ☐ Good ☐ Fair ☐ Non-swimmer

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want to be dispensed to your child:

Please list any additional information relevant to participating in Youth Group activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):
