Youth Name___________________________**Congregation**_________________________

Cell#:_________________________________

Central East Region of the UUA

PERMISSION FOR TRANSPORTATION AND AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT OF MINORS

I, _________________________________, the undersigned represent that I am the Parent/Guardian of : ___________________________. I grant permission for my child to participate in the following adult-supervised activity: ____. The activity will take place at the following location(s): _________________________________ from (date & time) ___________________________ to (date & time) ________________, and I grant permission for my child to be transported to, and from as well as during this event as described below by reasonable and safe means: __________________________________ ____.

I have read event rules in the registration form. I agree and hereby do release and hold harmless the Central East Region, the hosting member congregation and/or any and all adult supervising the activity, from and for any and all liability which may arise for damages, loss or injuries, either to person or property, which my child may sustain while engaged in the activity conducted, including, but not limited to, any damages, loss or injuries that may be sustained through transportation to and from the activity. Should any injury occur, I grant permission for my child to receive emergency treatment from an appropriate health care provider to be selected by the adult supervisor of the activity, when, in such supervisor's opinion, the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful. I also agree to pay and be responsible for all medical, hospital or other expenses which the Central East Region and/or any and all adult supervising may incur as a result of securing such treatment. I further agree to assume responsibility for any liability which may arise for damages, loss or injuries, as described herein which may be caused or contributed to by my child to the person or property of others.

Home street address and Email ____

____

Phone Numbers: Home: (____) __________________ Cell: (____) ______________________

Alternate Emergency name/phone number: ____

Name of Physician: ________________________ Physician's phone number: ______________

Health Insurance provider: ___________________ Policy/Group#: ________________________

Allergies: ________________________ Physical limitations: ___________________________

Current Medications/Other needs ____
(use back for further info)

____
(Parent/Guardian signature and date)