

UUFA Trip Permit and Medical Authorization

Event:

Date:

Adult in Charge:

Please complete the following, detach at above line, and return lower portion to DYCM or Adults in Charge above before event or when bringing your youth to the event. Youth without permission forms will not be allowed to participate in the event.

My youth _____ has my permission to attend the above event and will comply with the rules set by the group and the leaders. I understand that if my youth does not abide by these rules he/she may be asked to leave the event at my expense. Although the adult leader will be in attendance to supervise at all times, the UUFA or the individual leader cannot be responsible for accidental injuries. I am aware of and accept any risk inherent in my child's participation in this activity. I agree to hold harmless and indemnify the Unitarian Universalist Fellowship of Ames, its individual staff members, and all volunteer adults from any and all liability, loss, damages, cost, or expenses which may result from the actions of my child in the course of this activity.

Signature of Parent or Guardian

Date

Phone (day) _____ **(evening)** _____ **(cell)** _____

Please list any other phone numbers you may be reached at other than listed above while your child is engaged in this event:

Emergency and Non-Emergency Medical Authorization

I hereby authorize the emergency center staff at the closest medical facility to order any surgical or medical treatment, blood transfusions, anesthesia, or medication they may deem advisable for emergency care and treatment, with the exception of _____ (if acceptable as stated write "none") while my child is participating in this event. Every effort will be made to reach before any treatment is approved, if possible. I do/do not (**circle one**) give permission for immediate medical care for my child, _____. (Print child's name.)

Signature of Parent or Guardian

Date

Medication Administration

If your child takes any prescription or non-prescription medication (for allergies, asthma, headaches, etc.) please list them below. If your child can not administer their own medications, please contact Lori Allen to make certain the administration can happen safely while participating in the program. Please send only the doses that need to be taken to this event. Medication should be in the original container with attached pharmacy label and directions.

I hereby authorize my child to have these medications with them at this event, to be self-administered by my child.

Name of medication	Dosage	Instructions
1.		
2.		
3.		

Signature of Parent or Guardian

Date

Please list any known allergies to medications, food, or other substances; or any medical condition your child has of which medical personnel and adult advisors should be aware on back of form.