Unitarian Universalist Fellowship of Ames
1015 N. Hyland Ave.
Ames, IA 50014
515.292.5960
uufa@uufames.org

Trip Permission and Medical Authorization

Event :	
Event Date(s):	**Event Facilitator(s):**

Statement of Consent and Release from Liability:

I, the parent/guardian of ________________________________ (*first, middle, and last name*), do hereby give consent for my youth to attend the event listed above. I understand that my youth shall comply with the rules set forth by the group and its leaders, and that if they do not abide by these rules s/he may be asked to leave the event at my expense and responsibility. I will not hold the Unitarian Universalist Fellowship of Ames (UUFA), individual Event Facilitators and volunteers, or individual staff members responsible for accidental injuries. I further agree to hold harmless and indemnify the UUFA, 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 youth in the course of this activity.

Print Name: ________________________________

Signature: ________________________________ Date: ________________

Parent/Guardian's Consent for Emergency Medical Treatment:

I hereby authorize the UUFA Event Facilitator(s) for the above described event to secure a physician's service if, in their judgment, any illness or accident should deem such treatment necessary. I authorize medical personnel to order any surgical or medical treatment, blood transfusions, anesthesia, or medication they 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.

Print Name: ________________________________

Signature: ________________________________ Date: ________________

In the interest of community health and well-being, I will ensure that my youth does not attend the event if s/he is ill, and I will inform the Event Facilitator(s) at least 24 hours in advance. I understand the cost of the event, and that a refund is not available if my youth does not attend.

__________ *initial*

I understand that if my child is in need of any of the medications listed on the reverse of this form during this event, the medicine will be administered by the adult Event Facilitator(s) (or appropriate adult designee), must be stored in its original container complete with dosage instructions, and custody of *any and all* medications must be given to the Event Facilitator(s) and cannot remain in my youth's possession under any circumstances. Exceptions to this policy include insulin, inhalers, emergency allergy auto-injectors, and other medications or devices which might be used in life-threatening situations.

__________ *initial*

Parent/Guardian Contact Information:

Name: ______________________

Address: ______________________

Daytime Phone: ______________________

Evening Phone: ______________________

Cell Phone: ______________________

If, in the event of an emergency, I (parent/guardian) cannot be reached, the following person is authorized to act on my behalf:

Name: ______________________

Address: ______________________

Daytime Phone: ______________________

Evening Phone: ______________________

Cell Phone: ______________________

Relationship to participant: ______________________

Medication	Dosage	Instructions

Known Medical Conditions:

Allergies:

Dietary Restrictions:

Physician & Insurance Information:

Physician: ______________________

Physician's Phone: ______________________

Insurance Provider: ______________________

Policy #: ______________________

Policy Holder: ______________________

Miscellaneous/Other: