

AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR MINOR CHILD

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between Youth Action Community Council of Boone County, INC., hereinafter referred to as "Management"

and: _____, hereinafter referred to as "Parent."

Management is hereby authorized to obtain any and all medical treatment Management deems reasonably necessary for my minor child and/or children during their attendance in BASE programs. Parent or guardian agrees to bear any cost connected therewith and shall pay promptly upon billing by the health care provider. Management shall incur no financial liability for medical treatment obtained pursuant to this authorization.

Name(s) of Child (ren) and Social Security Number

Health Insurance Carrier: _____

Plan or Identification Number: _____

Primary Health Care Provider & Telephone Number: _____

Parent's Names and Emergency Telephone Numbers:

Mother's Name Work Telephone Home Telephone Cell Phone

Father's Name Work Telephone Home Telephone Cell Phone

WAIVER OF LIABILITY

I, _____ (Parent/Legal Guardian), hereby release **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) from any and all liability connected with my son(s)/daughter(s) participation in the companies' summer program and recreational activities. I acknowledge that they are participating in these activities on their own time and of their own choice and assume all risk in connection thereto. **Initials** _____

Consent to transport and waiver of liability

I hereby give consent for **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) staff members and Case Managers the right to transport my child/children _____ to the proper medical facility if such became necessary and/or to and from field trips. I waive my rights to hold **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) officers, agents, employees and/or any affiliated companies responsible for any liabilities arising from injuries my child/children and/or myself might suffer while transporting and/or participating in services. I understand and

agree that **Youth Action Community Council and/or Mental Health Association in Boone County** (companies) staff shall provide only that emergency treatment within its capabilities and that I assume full responsibility for any and all medical expenses incurred as a result of any injuries suffered. **Initials**_____

Signature of Parent or Guardian

Signature of Parent or Guardian

NOTE: THIS FORM MUST BE NOTIRIZED

STATE OF (_____)

)SS:

COUNTY OF (_____)

The foregoing instrument was subscribed and sworn to before me by

_____, Parent or Guardian,

on the ____ day of _____, _____.

NOTARY PUBLIC

My commission expires:
