Emergency Transportation Form

Youth's Name	Mother's Name	Father's Name
Home Address	Home Address	Home Address
City, State, Zip	City, State, Zip	City, State, Zip
Youth's Phone #	Phone: Mom's Cell:	Phone: Dad's Cell:
Youth's date of birth:	Employer's Name	Employer's Name
Youth's Grade:	Phone:	Phone:

LIST TWO PEOPLE BELOW WHO CAN BE CONTACTED IN AN EMERGENCY IF THE PARENT CANNOT BE REACHED:

Name		Name:	
Address		Address:	
Relationship to Youth:	Phone:	Relationship to Youth:	Phone:

Name of Physician or Clinic:		Name of Dentist or Clinic:	
Address:		Address:	
City, State, Zip	Phone:	City, Sate, Zip	Phone:

EITHER PART 1 OR PART 2 BELOW MUST BE COMPLETED. ***DO NOT COMPLETE BOTH.***
The form only authorizes the child care center to secure emergency transportation for a Youth. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility sets its own treatment procedures.

Part I. Permission to Transport Youth

I give **CROSSROADS ASSEMBLY OF GOD** my permission to transport my Youth ________________________________
(Name of Youth)
to ________________________________for emergency medical care or to __________________________ for emergency
(Hospital or Clinic) (Dentist, Dental Clinic)
dental care, or the nearest available source of assistance.

Parent's Signature:	Date:

Part II. Refusal To Grant Permission

I do not give permission to **CROSSROADS ASSEMBLY OF GOD** to transport my Youth _________________________
(Name of facility) (Name of Youth)
for emergency medical or dental care. In the event of an illness or injury which requires emergency or dental treatment, I wish the following action to be taken ____.

Parent's Signature:	Date:

Please turn over for page 2

HEALTH RECORD FORM

Please understand that all information given on this form will only be shared with necessary Youth workers and church staff. No Youth will be discriminated against due to health/medical problems. This information is to assist us in providing your Youth with the care that they need and to help us insure their safety.

____

Youth's Name **Grade** **DOB**

1. List all allergies and any special precautions and treatment indicated for these allergies: (foods, medications, or environmental allergies)
   ____
   ____

2. List medication: food supplements, modified diets, or fluoride supplements that would effect a Youth in case of field trip or overnight event:
   ____
   ____

3. List any chronic physical problems which might affect participation:
   ____

HEALTHCARE PLAN (To Be Completed If Your Youth Needs Specific Medical Attention**):**

Condition:
____
Symptoms to watch for:
____
Conditions to avoid that may cause symptoms:
____

What actions should be taken for these symptoms? (Please be specific)
____
____
____

Are there any medications required? No_______ Yes_______
If so, please explain:
____
____

Insurance Company Name____
Insured Person's Name____
Insurance Number____

Parent Signature:____

Date:__________________________________