Seneca Mentoring Youth Links
928 W. Market St. Suite A, Tiffin, Ohio 44883
Phone: 419-447-2927 Fax: 419-447-2825
SenecaSMYL@ncoesc.net

PERMISSION SLIP FOR AGENCY OUTINGS AND RELEASE OF LIABILITY

Child's Name:_____
Address:_____
_____
Home Phone:_____ Work Phone:_____

In Case of Emergency, Please Notify

Name:_____
Address:_____
_____
Home Phone:_____ Work Phone:_____

I hereby give my permission for_____
(Child's Name)
To participate in all SMYL agency sponsored activities.

As the natural and legal guardian of the above named child, I hereby certify to the best of my knowledge the said person is free from contagious disease, and is fit to participate in all agency activities. I hereby hold Seneca Mentoring Youth Links, the SMYL Mentors, SMYL Volunteers, SMYL staff participations organization FREE OF ALL LIABILITY resulting from participation in the activities organized by this agency. I understand that this permission may be revoked at any time in writing signed by me and received at the office of SMYL, and that unless revoked this permission and release will be relied upon by the SMYL staff, volunteers, and participation organizations.

_____ Date Signature of

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EMERGENCY MEDICAL AUTHORIZATION

Name:_____ DOB:_____ Parent/Guardian_____
Address:_____
Phone (home):_____ (cell/work)_____
PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the authority of a Mentor when Parents or Guardians cannot be reached. (1 or 2 must be completed)

PART 1 TO GRANT CONSENT

In the event reasonable attempts to contact me at_____(phone number) or (other parent or guardian) at _____ have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Dr._____(preferred physician) or Dr._____(preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to_____(preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

This authorization shall be valid during the period said child is officially affiliated with SMYL, unless revoked in writing by the undersigned.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be catered:

_____

_____

_____ _____ Signature of Parent/Guardian Date

PART 2 REFUSAL TO CONSENT (DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1) I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the Mentor to take no action or to:

_____

_____

_____ _____ Signature of Parent/Guardian Date

IN NON-MEDICAL EMERGENCY SITUATIONS IF THE PARENT CANNOT BE REACHED CONTACT THE FOLLOWING RELATIVE, FRIEND OR NEIGHBOR.

Name:_____ at Phone_____
Name:_____ at Phone_____