

# TYME OUT Youth Center

W332 N6786 County Road C

Nashotah, WI 53058

Phone 262-966-1800

## Parent/Legal Guardian Permission and indemnity Agreement

Name of Son/Daughter/Ward: \_\_\_\_\_

Parish/School: \_\_\_\_\_ Supervisor of Activity: \_\_\_\_\_

Activity: \_\_\_\_\_ Dates and Time: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_ Student Cost: \_\_\_\_\_

Registration Deadline: \_\_\_\_\_

I consent to the participation of my SON/DAUGHTER/WARD in the above named Activity. In consideration for my SON/DAUGHTER/WARD's participation, I agree to reimburse and indemnify the TYME OUT Youth Center for all reasonable legal and court fees incurred by TYME OUT in defending a lawsuit that I or my SON/DAUGHTER/WARD may bring against TYME OUT, which relates to the above named activity if TYME OUT is found not legally liable by the courts and prevails in the lawsuit. If the TYME OUT Youth Center is found legally liable for injuries sustained by son/daughter/ward, this paragraph will not apply.

I certify that I have an understanding of this agreement and any risks and hazards associated with the activity described above that my SON/DAUGHTER/WARD will be participating in. I further understand that I have the opportunity to fully discuss this agreement with a representative of the TYME OUT Youth Center to clarify any concerns or questions about the activity or this agreement that I may have.

PARENT/GUARDIAN'S NAME(S): \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Photo Release

I hereby give my permission to the TYME OUT Youth Center for photographs that may include my child's image to be used in promotional materials. This includes any prints, slides, copies, reductions, or any other processes or treatments necessary to make a photograph for reproduction purposes. I release all rights and privileges for financial obligations for this permission.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**(The other side of this form must be filled out and signed.)**

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**MEDICAL RELEASE FORM**

PARTICIPANTS NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX : M F

FAMILY DOCTOR \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

Family Health Plan Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

**MEDICAL MATTERS:**

I hereby warrant, to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. OF THE FOLLOWING STATEMENTS (pertaining to medical matters) SIGN ONLY THOSE IN ACCORDANCE WITH YOUR WISHES.

**EMERGENCY MEDICAL TREATMENT:**

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any farther treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above number, contact:

NAME & REALTIONSHIP: \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ BUSINESS PHONE (\_\_\_\_) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OTHER MEDICAL TREATMENT**

In the event it comes to the attention of the DESIGNATED SUPERVISOR or staff that my SON/DAUGHTER/WARD becomes ill with symptoms of headache, vomiting, sore throat, fever, or diarrhea, I DO want to be called collect (with phone charges reversed to myself if necessary)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATIONS**

My SON/DAUGHTER/WARD is taking medications at present and will bring all such medications necessary, and such medications will be well-labeled. I give permission for my SON/DAUGHTER/WARD to take this medication on his/her own. The dosage and frequency of dosage is as follows:

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If requested, I DO give permission for my SON/DAUGHTER/WARD to be given the following (please circle)**

Asprin	Benedryl	Midol	Ibuprofen	Pepto Bismo	Cough Drops
Tums	Aspicream	Sudafed	Primatene Mist	Tylenol	Other _____

Signature \_\_\_\_\_ Date \_\_\_\_\_

**NO MEDICATION OF ANY TYPE**

No medication of any type, whether prescription or nonprescription, may be administered to my SON/DAUGHTER/WARD unless the situation is life threatening and emergency treatment is required.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SPECIAL MEDICAL INFORMATION**

The parish/school will take reasonable care to see that the following information will be held in confidence.

Allergic Reactions (medicine, food, plants, insects, etc.): \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? \_\_\_\_\_

Has child recently been exposed to a contagious disease (ex. Mumps, measles, chicken pox, etc.) If so, please list date and disease \_\_\_\_\_

You should be aware to these special medical conditions of my child \_\_\_\_\_