PERMISSION FORMS
Iowa National Guard Youth and Teen Program
Rev. 1 Jan 2011

Youth/Teen Name: _____ **Date**: _____

Parent/Guardian Name: _____

Contact Numbers: _____ _____
Cell Number Back-up Emergency Number

RELEASE FORM:

Event: 2011 Youth and Teen Symposium

By signing this form, I agree to allow my youth (name listed above) to participate in the activity/event listed above. In addition, I release the Iowa National Guard and its employees, contractors and volunteers from any responsibility or liability regarding any possible injury/death that might occur to my child. This release does not waive any statutory right conferred by act of congress or the Iowa General Assembly.

Parent or Legal Guardian Signature Date

PHOTO/PRESS RELEASE:

I understand the National Guard Youth Program is developing photographic and multimedia materials, which will illustrate events occurring throughout the year for the Iowa National Guard Youth Program. I grant the National Guard Youth Program and its associated staff and subordinate entities the right to take, use, reproduce, assign and/or distribute photographs, films, non-confidential information, videotapes and sound recordings of the Iowa National Guard Youth Program participants, for use in any such materials as the National Guard Youth Program or its associated entities may create, without any payment to or future approval by me. I concur that there shall be no payment for such use.

Parent or Legal Guardian Signature Date

MEDICAL RELEASE:

Complete the information below. If your youth/teen has allergies, medication needs or any other medical condition we need to be aware of, please let us know.

YES NO Medical condition or needs that require monitoring: _____

_____

YES NO Allergies (Food, medicine, insects, etc.): _____

_____

YES NO Currently taking medication (including prescription or over-the-counter medication):

_____

YES NO My youth/teen has permission to administer his/her own medication. If "NO", the following individual will dispense all medication to my youth/teen: _____

In order to dispense medication we need to know the following:

- □ Condition for which it is given: _____
- □ Exact name of medication(s): _____
- □ Dosage: _____
- □ When it should be given: _____

NOTE: All medication must be in its original container to include any items (inhalers, spoons, cups, etc.) which will be needed to properly dispense the medication.

Parent or Legal Guardian Signature Date

MEDICAL ADMINISTRATION RECORD:

DATE	MEDICATION	DOSAGE	TIME	ADMINISTERED BY

AUTHORIZATION TO TREAT:

I hereby give permission to medical personnel selected by _____ to provide for
(Parent/Guardian)
emergency medical treatment and necessary transportation for my youth/teen. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by _____ to secure
(Emergency Contact with number)
and administer treatment including hospitalization of the above mention youth/teen.

Parent or Legal Guardian Date