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# YOUTH FORUM Conference Annual Meeting

## Permission Form

**(Please Print)**

I / We \_\_\_\_\_  
(parent / guardian name)

give permission for \_\_\_\_\_  
(participant's name)

to participate in the Bay of Quinte Conference Youth Forum.

During the time of Youth Forum (May 28 – 30, 2010) I/we will be available by phone at the following numbers:

Home: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**(Please check off the permissions granted and sign the form at the bottom of the page.)**

\_\_\_\_\_ **PERMISSION TO PARTICIPATE** (for those under 18 years of age):  
Permission is granted for our son/daughter to fully participate in the Youth Forum of Bay of Quinte Conference, The United Church of Canada, to be held at Brockville Memorial Centre and St. Lawrence College, Brockville. Participation will include physical activities such as walking, games, outdoor activities, etc.

Please list anything that would limit participation:

\_\_\_\_\_

\_\_\_\_\_ **PHOTOGRAPH AND VIDEO RELEASE**  
I give permission for the photograph and/or video image, of myself/my child, as taken by authorized persons, to be used as memory or promotional material in various United Church of Canada print and electronic resources, including online community locations and Bay of Quinte Conference web site for the promotion of Youth Forum and Youth Events in Bay of Quinte Conference of The United Church of Canada.

\_\_\_\_\_ **HEALTH INFORMATION:**

(**Important:** This information is necessary to participate in Youth Forum)

Allergies: \_\_\_\_\_

Special diet (i.e. vegetarian): \_\_\_\_\_

Current medication(s): \_\_\_\_\_

Dosage and Frequency: \_\_\_\_\_

Self Administered: \_\_\_\_\_

or Administered by an adult: \_\_\_\_\_

Special needs: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ **PERMISSION FOR EMERGENCY MEDICAL ATTENTION**

Permission is given for leaders or their designate to permit emergency treatment for my daughter / son if it is deemed necessary. All efforts will be made to contact the parent or guardian before permission for treatment is given.

\_\_\_\_\_ **PERMISSION TO ADMINISTER NON PRESCRIPTION DRUGS:** (such as Tylenol for headaches, etc.)

**Signatures:**

Parent / Guardian Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

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

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

**Return this form with your Registration Form**