

## **Permission Form**

RELEASE FORM  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 Missouri National Guard and its employees, contractors and volunteers from any responsibility or liability regarding any possible injury/death that might occur to my child.  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 Missouri National Guard Youth Program. I grant the National Guard Youth Program and its associate staff and subordinate entities the right to take, use, reproduce, assign and/or distribute photographs, films, nor confidential information, videotapes and sound recordings of the Missouri National Guard Youth Program, for use ir 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.  AUTHORIZATION TO TREAT & MEDICAL RELEASE  I hereby give permission to medical personnel selected by the local Emergency Medical Team to provide for emergency medical treatment and necessary transportation for my youth in the event I cannot be reached in an emergency, I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth.  — (please initial or sign here.)  If your youth has allergies, medication needs or any other medical condition we need to be aware of, please let us know. When possible, please administer medications prior to or after the event. NOTE: All Medication must be in its original container to include any items (inhalers, spoons, cups, e.c.) which will needed to properly dispense the medication.    YES	Youth Name		Parent/Guardian Name	Date
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 Missouri National Guard and its employees, contractors and volunteers from any responsibility or liability regarding any possible injury/death that might occur to my child.  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 Missouri National Guard Youth Program. I grant the National Guard Youth Program and its associate staff and subordinate entities the right to take, use, reproduce, assign and/or distribute photographs, films, not confidential information, videotapes and sound recordings of the Missouri 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.  AUTHORIZATION TO TREAT & MEDICAL RELEASE  I hereby give permission to medical personnel selected by the local Emergency Medical Team to provide for emergency medicat treatment and necessary transportation for my youth in the event I cannot be reached in an emergency, I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth	Contact I	Numbers		
release the Missouri National Guard and its employees, contractors and volunteers from any responsibility or liability regarding any possible injury/death that might occur to my child.  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 Missouri National Guard Youth Program. I grant the National Guard Youth Program and its associate staff and subordinate entities the right to take, use, reproduce, assign and/or distribute photographs, films, nor confidential information, videotapes and sound recordings of the Missouri 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.  AUTHORIZATION TO TREAT & MEDICAL RELEASE  I hereby give permission to medical personnel selected by the local Emergency Medical Team to provide for emergency medicat treatment and necessary transportation for my youth in the event I cannot be reached in an emergency. I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth	RELEASI	E FORM		
I Understand the National Guard Youth Program is developing photographic and multimedia materials, which will illustrate events occurring throughout the year for the Missouri National Guard Youth Program. I grant the National Guard Youth Program and its associate staff and subordinate entities the right to take, use, reproduce, assign and/or distribute photographs, films, nor confidential information, videotapes and sound recordings of the Missouri National Guard Youth Program participants, for use ir 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.  **AUTHORIZATION TO TREAT & MEDICAL RELEASE**  I hereby give permission to medical personnel selected by the local Emergency Medical Team to provide for emergency medicat treatment and necessary transportation for my youth in the event I cannot be reached in an emergency, I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth	release th	ie Missou	ri National Guard and its employees, contractors and volunteers for	
events occurring throughout the year for the Missouri National Guard Youth Program. I grant the National Guard Youth Program and its associate staff and subordinate entities the right to take, use, reproduce, assign and/or distribute photographs, films, nor confidential information, videotapes and sound recordings of the Missouri 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.  ### AUTHORIZATION TO TREAT & MEDICAL RELEASE**  I hereby give permission to medical personnel selected by the local Emergency Medical Team to provide for emergency medical treatment and necessary transportation for my youth in the event I cannot be reached in an emergency, I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth	PHOTO/F	RESS R	<u>ELEASE</u>	
I hereby give permission to medical personnel selected by the local Emergency Medical Team to provide for emergency medicate treatment and necessary transportation for my youth in the event I cannot be reached in an emergency, I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth	events oc and its as confidenti any such	curring the sociate se al informa materials	troughout the year for the Missouri National Guard Youth Program taff and subordinate entities the right to take, use, reproduce, assignation, videotapes and sound recordings of the Missouri National Gas the National Guard Youth Program or its associated entities m	<ul> <li>I grant the National Guard Youth Program gn and/or distribute photographs, films, non- uard Youth Program participants, for use in</li> </ul>
treatment and necessary transportation for my youth in the event I cannot be reached in an emergency, I herby give permission to the physician selected by the EMT to secure and administer treatment including hospitalization of the above mentioned youth	<u>AUTHOR</u>	IZATION	TO TREAT & MEDICAL RELEASE	
possible, please administer medications prior to or after the event. NOTE: All Medication must be in its original container to include any items (inhalers, spoons, cups, etc.) which will needed to properly dispense the medication.    Medical or Developmental needs that require monitoring or accommodations (Please tell us what helps your child calm down or happy when upset if behavioral)    YES	treatment to the phy youth	and necessician se	essary transportation for my youth in the event I cannot be reached lected by the EMT to secure and administer treatment including ho	d in an emergency, I herby give permission ospitalization of the above mentioned
□YES       □NO       (Please tell us what helps your child calm down or happy when upset if behavioral)         □YES       □NO       Allergies (Food, Medicine, Insects, etc.)         □YES       □NO       Currently taking medication (including prescription or over-the-counter medication)         □YES       □NO       My Youth has permission to administer his/her own medication. If "NO" the following Individual will dispense all medication to my youth         In order to dispense medication we need to know the following         Condition for which it is given         Exact name of medication(s)         Dosage	possible,	please ad	dminister medications prior to or after the event. NOTE: All Medica	tion must be in its original container to
□YES       □NO         □YES       □NO         Currently taking medication (including prescription or over-the-counter medication)         □YES       □NO         My Youth has permission to administer his/her own medication. If "NO" the following Individual will dispense all medication to my youth         In order to dispense medication we need to know the following         Condition for which it is given         Exact name of medication(s)         Dosage	□YES	□NO		ral)
□YES       □NO       My Youth has permission to administer his/her own medication. If "NO" the following Individual will dispense all medication to my youth         In order to dispense medication we need to know the following         Condition for which it is given         Exact name of medication(s)         Dosage	□YES	□NO	Allergies (Food, Medicine, Insects, etc.)	
In order to dispense medication we need to know the following  Condition for which it is given  Exact name of medication(s)  Dosage	□YES	□NO	Currently taking medication (including prescription or over-the-counter medication	on)
Condition for which it is given  Exact name of medication(s)  Dosage	□YES	□NO		owing Individual will dispense all medication to
Exact name of medication(s)  Dosage	In order to	o dispense	medication we need to know the following	
Dosage	Condition 1	for which it	s given	
	Exact nam	e of medica	ntion(s)	
When it should be given	Dosage			
1	When it sh	ould be giv		

Parent or Legal Guardian Signature Date