Youth Name:		**Date:**
Parent/Guardian Name:		**Date:**

"Striving for Excellence"

PARENT/GUARDIAN FORM FOR YOUTH PARTICIPATION
Field trips, community service projects, and other special activities

Dear Parent(s) or Legal Guardian(s):
Your child(ren) is invited to participate in the afterschool program Game Changer, currently operating at Cascade Galleria, Suite 140, St, New Castle, PA 16101.
Throughout the year, we will engage in a variety of events and community service activities with or without other agencies/programs. If you would like your child to be participate in the Game Changer program, please complete, print, sign, and date (on the back), and return.
If you have any question, please contact Laura Colvin at (724) 510-8689 (please leave detailed message).

I (print your name)_____, (relationship)_____, give permission for (child's name) _____, to participate in the Game Change Program. I understand that this program's curriculum may take place at or other than Cascade Galleria, and **(initial)** I _____do _____ **DO NOT** authorize my child(ren) to be transported via private vehicle(s). I understand that my child(ren) will be under the supervision of the staff/volunteers of Game Changer during those times. As parent or legal guardian, I remain fully responsible for any legal responsibility that may result from any personal action(s) done by my child(ren) on the back of this form.

MEDICAL:

Emergency contact: Name: _____, relationship _____ # _____/_____; Hospital preference: _____ Physician name:_____;

Health/dental insurance_____

additional/special instructions: _____

MEDIA: (initial)

I _____ do _____ **DO NOT** authorize the circulation of photographs or any media type materials by the GC staff, social media, newspapers, TV and or radio.

Youth Name:		**Date:**
Parent/Guardian Name:		**Date:**

SCHOOL: (initial)

I _____ do _____ DO NOT authorize Game Changer to correspond with teachers/counselors regarding my child's academic status, including attendance, or access to academic records.

MEDICAL/HEALTH CONCERNS/INFO

ALLERGIES	PHYSICAL	MENTAL	SEIZURE	SPECIAL INSTRUCTIONS/medications

School	Grade	DOB/ AGE	SEX	ED/CAREER GOALS	INTERESTS

YOUTH INFO

ADDITIONAL INSTRUCTIONS_____

_____

_____

PRINT Name **Signature/date**

_____

Address

Phone number(s): _____

_____

AUTHORIZED PICKUP CONTACT/LIST:

Name_____ Phone _____Relationship_____

Name_____ Phone _____Relationship_____

Name_____ Phone _____Relationship_____

THERE IS NO OTHER PERSON(S) AUTHORIZED TO PICK UP MY CHILD

SIGN AND DATE: _____/_____