|  |
| --- |
|  |
| Parental/Guardian Consent and Liability Release form |
| As the parent or legal guardian of the child named below, I hereby give my full consent and approval for my child to participate as a mentee with Creating A Breakthrough LLCIn addition to giving my full consent for my child’s participation, I do hereby waive, release and hold harmless Creating A Breakthrough LLC, its officers, mentors for any injury that may be suffered by my child in the normal course of participation of activities incidental thereto, whether the result of negligence or any other cause |
| Permission is granted for:(Name of Student) PLEASE PRINTPick up from the residence, Newark Educators Community Charter School or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PARENT/GUARDIAN INFORMATION: |
| Parent/Guardian Name:  |
| Address:  |
| Phone #:  | Emergency Phone #:  |
| Please provide the information requested below, as it may be needed in case of an emergency. Student’s Date of Birth |
| Allergies:  |
| Conditions requiring special consideration (medical/physical): |
| Does your student require: (A) **Epipen** Yes □ No □ (B) **Inhaler** Yes □ No □ (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration):  |
| I give permission for Creating A Breakthrough LLC to use photo/video for social media taken during the designated time of activities.  |
| Primary contact name  | Relationship to student:  |
| Phone #:  | Work Phone #:  | Cell Phone/Pager #:  |
| Secondary contact name  | Relationship to student:  |
| Phone #:  | Work Phone #: | Cell Phone/Pager #: |
| Student’s Physician:  | Phone #:  |
| **TO ANY DOCTOR OR HOSPITAL:** I hereby authorize the release of my child’s pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child during this field trip. |
| HEALTH INSURANCE INFORMATION: |
| Company Name:  | Policy #:  | Group #:  |
| Parent/Guardian Name:  | Date:  |
|  |
| Parent/Guardian Signature:  |