Medical Permission Form

My son/daughter, _____ (print name) has my permission to receive any medical treatment in case of medical emergency or an illness. I authorize any licensed physician to give such treatment, as he/she deems necessary to protect my son's/daughter's health, including but not limited to, surgery and the administration of medical drugs. I agree to bear the responsibility for all expenses incurred in connection therewith.

My son/daughter is allergic to: _____

My son/daughter has the following medical condition and/or is currently taking the following medications: _____
_____

Signature and Date of Mother/Guardian: _____

Address:_____Phone:_____
Work/Cell#:_____Pager:_____
Emergency contact name and phone number: _____
Medical Insurance Provider_____Policy#:_____
Name of Insured:_____

Consent and Release for Publication

I understand that the Student Service Advisory Council of the South Bay (SSAC) and other associated youth service groups are community service organizations. I further understand that from time to time, my son/daughter and/or I may be photographed and/or interviewed by/for various publications. I hereby consent that SSAC and other affiliated service organizations may release my son's/daughter's or my own name/or image to various publications in relation to any SSAC event or activity.

Son/Daughter Name: _____

Mother's Name: _____

Mother's Signature: _____

Date: _____