



SOUL ASYLUM YOUTH INFORMATION & CONSENT

Name of Student: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Names of Parents or Guardians: _____

Phone Number of Parents/Guardians: _____

Email of Parents/Guardians: _____

Best Way to Contact Parents/Guardians:

Home Phone

Cell Phone

Email

Other

If Other, please specify: _____

Does the above student have any allergies that the youth leaders should be aware of? Please specify.

Is the above student taking any medications that the youth leaders should be aware of? Please specify.

Would the above student be bringing these medications to Soul Asylum or would these medications potentially need to be taken at Soul Asylum?

Does the above student have any medical conditions the youth leaders should be aware of? Please specify.

Are there any procedures or information the youth leaders need to be aware of or for which they need to have knowledge in order to deal with the above medical conditions?

Who would the youth leaders contact in case of emergency? Please include other family members in case the leaders cannot reach parents/guardians and or doctor name and contact information.

Is there any other information the youth leaders need to know? Please specify.

Parent/Guardian Permission

I, _____, give permission for my child, _____ to participate in the Soul Asylum Program at Soul Sanctuary. I understand that this is a voluntary program and that me and my child assume all risks associated with participating in the Program.

At any time due to such circumstances as accidents or sudden illness, I hereby give permission for emergency medical treatment to be obtained for my child. I understand that a Youth Leader will attempt to contact me prior to leaving the location where Soul Asylum is being held for that particular evening or upon arriving at the emergency destination.

Signature of Parent, Legal Guardian or
Other Authorized Person

Date