Streethearts
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PARENTAL CONSENT FORMS FOR MINORS TRAVELING WITHOUT PARENT(S)

This form gives consent to Streethearts, Inc. volunteer staff member, Kelly Hamric, regarding:

"AUTHORIZATION FOR FOREIGN TRAVEL WITH MINOR(S)"
"AUTHORIZATION FOR MINOR'S MEDICALTREATMENT"

AUTHORIZATION FOR FOREIGN TRAVEL WITH MINOR:

This letter is in relation to my child, _____ [name of child], who is a citizen of the United States of America and a minor born on _____ [specify child's date of birth]. My child holds a U.S. passport with the number _____.

I do solemnly swear that I have legal custody of my child and that no pending divorce or child custody proceedings involving my child exist. I do hereby grant full authorization and consent for my child to travel outside of the United States with Streethearts, Inc, volunteer staff member, Kelly Hamric.

_____ [parent initial].

I am aware that at times it may be difficult to be contacted, and in an emergency situation, I authorize Kelly Hamric to make medical decisions regarding my child.

_____[parent initial].

I am aware that the purpose of the travel is volunteer work with the organization Streethearts, Inc, located in Cap-Haitien, Haiti. I am aware that Haiti is an underpriviledged country and I understand the state departments warnings regarding traveling there.

_____ [parent initial].

I have approved the following travel plans:
Dates of travel: **July 19- 24**

Destinations/Accommodations: **Port-Au-Prince & Cap-Haitien – residing at the Exec.Director's Apt.**

I authorize Streethearts, Inc. travel plans specified above. _____

_____[parent initial].

*Under penalty of perjury under the laws of the state of ___**Virginia__,** I attest to the truthfulness, accuracy, and validity of the forgoing statement.*

Parent's Signature_____ / Date: _____

Parent's Signature_____ / Date: _____

PARENT(S)/LEGAL GUARDIAN(S)

Parent #1 Information:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Additional Contact Information: _____

_____

Parent #2 Information:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Additional Contact Information: _____

_____

AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT:

Child:

Full Legal Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Doctor's Information:

Doctor's Name: _____

Doctor's Address: _____

Doctor's Office Phone: _____ Doctor's Emergency Phone: _____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

If applicable, please note the conditions for which the child is currently receiving treatment:

_____

Note any other significant medical information:

_____

_____

Dentist's Information

Dentist's Name: _____

Dentist's Address: _____

Dentist's Office Phone: _____ Dentist's Emergency Phone: _____

Dentist's Insurer/Health Plan: _____ Policy #: _____

Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: _____ Relationship to child/family:_____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Additional Contact Information: _____

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S):

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.
I grant my authorization and consent for Streethearts, Inc. adult volunteer staff to administer general first aid treatment for any minor injuries or illnesses experienced by the minor (child). If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.
It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing on (first day of travel) the _____ day of _____, _____.

Parent 1's Signature_____ / Date: _____

Parent 1's Signature_____ / Date: _____

STATE OF _____

COUNTY OF _____