FY 2018-19 **Youth Alternatives, Inc.**

Please indicate interests of the youth being enrolled:	**Referring Agency/Program:**

One Graff Street, Oil City, PA 16301 **1250 Elk Street, Franklin, PA 16323**
814- 676-5785 Fax: 814- 677-0697 **814-346-0188**
Email: kids.rule@yavenangocounty.org Executive Director, Corrina Woods

REGISTRATION AND RELEASE FORM

REGISTRATION
Name of Youth being enrolled: _____

Youth's Birth Date: _____ Youth's Social Security Number: _____

Has the above youth ever been put in placement through CYS, JPO (please circle if yes), or indicate other? _____

Parents/Guardians _____
(First & Last Names of ALL Parents/Guardians in Household)

Street_____ City_____ State_____

Zip Code_____Home Phone_____ Other Phone_____

In case of emergency contact_____ Phone_____

Or contact_____ Phone_____

Number of YOUTH in Household: _____

Number of Adults in Household: _____

LIABILITY RELEASE
Above youth may be participating in Youth Alternatives programs. I acknowledge the risks and potential risks of some Youth Alternative's programs. However, I feel that the possible benefits to me/my son/my daughter ward are greater than the risks assumed. I hereby am intending to be legally bond for myself, my heirs and assigns, executor or administrators, waive and release forever all claims for damages against Youth Alternatives of Oil City, Inc., its board of directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I, my son/my daughter/my ward may sustain while participating in the Youth Alternative program.

Date:_____ Signature:_____
(youth if 18 yrs old, parent, or guardian)

PHOTO REALEASE
I hereby consent to and authorize the use and reproduction by Youth Alternatives of Oil City, Inc., of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, and exhibitions or for any other use for the benefit of the program.

Date:_____ Signature:_____
(youth if 18 yrs old, parent or guardian)

YOUTH ALTERNATIVES, INC.

1 Graff Street, Oil City, PA 16301 **1250 Elk Street, Franklin, PA 16323**
814-676-5785 Fax: 814-677-0697 **814-346-0188**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that emergency aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Youth Alternatives of Oil City, Inc. to:

1. Secure and retain medical treatment and transportation if needed,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name of Enrolled Youth: _____ Phone: _____

Address: _____

In the event that I cannot be reached, Contact: _____ Phone: _____
or Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____
Health Insurance Co.:_____ Policy #: _____

CONSENT PLAN
This authorization includes x-ray, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: _____ Date: _____
(Youth if 18 yrs. Old or Parent or Guardian)

NON-CONSENT PLAN
I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency aid/treatment is required, I wish the following procedures to take place:

Non-Consent Signature: _____ Date: _____

Print Name of Person Signing Form: _____

Phone: _____

Additional Health/Medical Comments (if Needed):