This application is intended as a means of informing and gaining the consent of the parent/guardian to allow their son/daughter to participate in the RESP Youth Companion program.

Youth's Name: ___________________________________ Date: ________________

School: ____

Parent or Guardian please initial each of the following:

_______I authorize the RESP Youth Companion program to obtain any needed information regarding my child from his/her school's staff, including academic and behavioral records and conversations with teachers, counselors, and other administrative staff.

_______ I give my informed consent and permission for my child to participate in the RESP Youth Companion program and its related activities. I understand that youth companions are not employees of CYFS, and that his/her commitment to the program is completely voluntary.

_______ I agree to have my child follow all mentoring program guidelines and understand that any violation on my child's part may result in suspension and/or termination of the mentoring relationship.

_______ I hereby acknowledge that my child will be transported by his/her mentor and/or RESP Youth Companion staff or representatives while participating in the RESP Youth Companion program, and that while all mentors and staff are screened and have adequate insurance, such transportation is voluntary and at his/her own risk.

_______ I release the RESP Youth Companion program of all liability of injury, death, or other damages to me, my child, family, estate, heirs, or assigns that may result from his/her participation in the program, including but not limited to transportation, and hold harmless any the RESP Youth Companion program mentor, program staff, or other CYFS representatives, both collectively and individually, of any injury, physical or emotional, other than where gross negligence has been determined.

_______ (optional) I agree to allow the RESP Youth Companion program to use any photographic image of my child taken while participating in the mentoring program. These images may be used in promotions or other related marketing materials.

Medical History

Name of Primary Care Physician: ________________________ Phone No.:__________

Medical Insurance Provider: _____________________________________

Policy Number: __________________________ Phone No.: _____________

Does your son/daughter have any physical problems or limitations?

Is your son/daughter currently receiving treatment for any medical issues?

Is he/she currently on any type of medication? Is so, please specify.

Does your son/daughter have any known allergies or adverse reactions to medications? If yes, please describe them below:

Does your son/daughter have any emotional issues or problems right now?

By signing below, I attest to the truthfulness of all information listed on this application and agree to all the above terms and conditions.

____ ____________

Parent/Guardian Signature Date