



CHILDREN'S
HOME SOCIETY
Washington

AUTHORIZATION TO TRANSPORT CONSUMER FOR APPOINTMENTS OR OUTINGS

This form allows the parent/legal guardian to indicate their choice regarding their child being transported for service delivery by or with CHSW staff. Consult the "Transportation" policy for full details, and "Recreational Activities" policy/related forms for situations of children participating in recreational outings.

Child's Name _____ CHSW # _____

Address/City/Zip _____

Home Phone: (_____) _____ Emergency Phone: _____

Birth Date: _____ Gender _____ Grade _____ School _____

I, the undersigned parent/legal guardian of the above-named child, understand that TRANSPORTING my child, by or with CHSW staff as needed for services within this program, may include the following, and hereby direct program staff:

I PERMIT DECLINE transporting my child to/from appointments.

I PERMIT DECLINE transporting my child to/from school for appointments.

I PERMIT DECLINE transporting my child to/from educational service-related outings.

I PERMIT DECLINE other transporting (location & reason) : _____

I understand transporting is by or with CHSW staff who have **appropriate Driver Authorization paperwork on file, in private or agency-owned vehicles, or by public transit.** I release from harm and liability and hold CHSW blameless for injury or damages incurred during such transporting.

MEDICAL CONSIDERATIONS

(To be completed for situations of TRANSPORTING only)

In case of illness or accident during transporting, if I cannot be contacted immediately, I give my permission to CHSW to obtain medical treatment for the above named child. I hereby consent to the administration of any and all medical procedures deemed necessary by the medical providers.

EMERGENCY CONTACT DURING TRANSPORTING:

Name _____ Relationship to Child _____

Phone (daytime) (_____) _____ (evening) (_____) _____

Address/City/Zip _____

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Child's Name _____

CHSW # _____

I certify that my child does NOT have any medical or physical conditions, which would interfere with his/her safety during transporting.

MEDICAL INFORMATION, PROBLEMS, OR ALLERGIES I WANT TRANSPORTING STAFF TO BE AWARE OF:

Child's Physician _____ Phone (____) _____

Medical problems, allergies, or concerns: _____

When transporting is ongoing for the duration of services, this authorization remains in effect for as long as this child is involved with CHSW , or until I notify CHSW in writing of an earlier cancellation date. I acknowledge by my signature that I have read, understand, and agree to the above information, and I give permission for my child to be transported by or with CHSW staff and receive emergency medical treatment, as necessary.

Parent/Legal Guardian

Date

CHSW Staff

Date

Form # 0194-101-9/07

Latest revision: 8/09

Two (2) original signed copies:

(1) in "Medical" section (or Consents" if declined/ no medical information)

(1) with staff during transport

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