

PARENT'S/GUARDIAN'S/OR LEGAL CUSTODIANS  
**PERMISSION FOR MINOR TO PARTICIPATE AND CONSENT FOR  
EMERGENCY MEDICAL TREATMENT**

**Full Name and Address -Of Parent/Guardian/or Legal Custodian:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Residence Address \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Other Emergency Phone Number (specify) \_\_\_\_\_

Full Name of Minor \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

I, \_\_\_\_\_, hereby give permission for \_\_\_\_\_  
(Print name of parent, guardian, or legal custodian) (Print name of minor)

to participate as a volunteer in City of Jacksonville's Volunteer Service Program. I, \_\_\_\_\_  
(Parent, guardian, or legal custodian)

further consent that the City of Jacksonville, its applicable Department or Division, obtain necessary emergency  
medical treatment and/or transportation for \_\_\_\_\_ in the event of accident, injury  
(Print name of minor)

or sudden illness while said minor is engaged in the City of Jacksonville Volunteer Service Program.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Parent, guardian or legal custodian)

**Medical Information and Disclosure**

Said minor has the following special medical conditions (including allergies): \_\_\_\_\_

\_\_\_\_\_

Said minor currently takes the following medications (prescription or otherwise): \_\_\_\_\_

\_\_\_\_\_

Physician's Name and Address: \_\_\_\_\_

Physician phone: \_\_\_\_\_ Date of Last DPT or Tetanus: \_\_\_\_\_

Insurance Coverage: \_\_\_\_\_