



Adolescents Choosing Excellence

PARENTAL CONSENT AND EMERGENCY INFORMATION FOR ACE SUMMIT

THIS CONSENT FORM IS TO BE SIGNED ONLY AFTER UNDERSTANDING AND AGREEING TO THE INFORMATION BELOW. IF THIS FORM IS NOT COMPLETED AND RETURNED PRIOR TO THE ACE YOUTH SUMMIT, THIS PERSON WILL NOT BE PERMITTED TO PARTICIPATE IN THE SCAVENGER HUNT AND PHYSICAL ACTIVITIES AT THE JACKSONVILLE ZOO AND GARDENS.

We are pleased to invite your son/daughter to the ACE Youth Summit. The purpose of ACE is to involve youth from countywide organizations in promoting awareness of and advocacy for healthy behaviors among Jacksonville's youth, specifically focusing on healthy eating, increased physical activity, tobacco and alcohol avoidance, and abstinence.

The Women of Color Cultural Foundation, Inc. has partnered with the Duval County Health Department and War on Poverty, to form a Youth Health Advisory Committee. We would like to invite your child to participate in the countywide summit which will be held on July 28, 2010.

Expectations and Instructions

I understand the following is expected of the youth.

- To follow instructions given by the adult chaperone.
- Not to leave or separate from the group without appropriate authorization from the chaperone.
- Comply with the rules of conduct.

In the event any of the above expectations or instructions are violated, I understand my son/daughter will be removed from activities and will wait in a supervised area until picked up by parent or guardian.

Insurance Coverage

I represent that the youth listed below has insurance.

I REQUEST THAT THE BELOW- NAMED YOUTH BE ALLOWED TO PARTICIPATE IN THE 2010 ACE YOUTH SUMMIT AND SPECIFICALLY CONSENT TO MY SON/DAUGHTER'S PARTICIPATION.

Name of Youth _____ School _____

Parent/ Guardian _____ Date _____

Youth's Signature _____ Date _____

PARENT/LEGAL GUARDIAN MEDICAL EMERGENCY AUTHORIZATION

In the event of a medical emergency while my child is participating in any ACE-related event, I authorize the Women of Color Cultural Foundation officials to release the following information to the healthcare provider. I understand the necessary officials will use the contact information provided below to contact me in the event of such emergency. If any emergency medical procedures or treatment are required during the trip, I consent to my son's/daughter's chaperone(s) arranging for and consenting to the procedures or treatment in my son's/daughter's chaperone(s) discretion. I will pay the costs of any such medical procedures or treatment.

Women of Color Cultural Foundation, Inc.

P. O. Box 43632

☛ P. O. Box 43632 ☛ ☛ (904) 665-2525 ☛

Parent/ Guardian _____ Date _____

EMERGENCY CONTACT INFORMATION

1ST CHOICE
NAME: _____
PHONE: _____
OTHER CONTACT INFO: _____

2ND CHOICE
NAME: _____
PHONE: _____
OTHER CONTACT INFO: _____

EMERGENCY MEDICAL INFORMATION

Family Physician: _____ Phone Number: _____

Allergies (including food): _____

Medication(s) taken routinely: _____

Special health needs: _____

Name of insurance company: _____ Policy #: _____