***Completed by person to be transported or parent/guardian of child to be transported.***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the person named above haven any special transportation needs, allergies, or any medical condition or health problems of which Community Health Center staff should be aware? NO \_\_\_\_\_ YES \_\_\_\_\_ If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the risks involved in transportation. I hereby waive and release all claims for damages against the Community Health Center of Cowley County (CHCCC) and its employees.

In the event the above-named person is taken to an emergency room or medical care facility at any time during transportation and/or associated activities, any employee of CHCCC has my consent to authorize treatment which may be deemed necessary by a doctor and/or medical personnel. I do hereby agree to assume full responsibility for any and all medical expenses resulting from any accident or injuries suffered by the above-named while participating in transportation and/or associated activities.

Children will be secured in an age appropriate car/booster seat provided by CHCCC and as required by law. Children who are old enough and all adults will be required to fasten their seat belts. No person will be transported if refusal to be secured in the vehicle occurs. CHCCC assumes no responsibility for riders once transportation services are completed.

By using CHCCC transportation services, you forfeit the right to confidentiality that you are a recipient of services of the CHCCC. No other form of information will be released about these services except for what is covered in this form. CHCCC has the expectation you will hold confidential any other parties making use of these transportation services in the same vehicle as you.

**I agree:**

1. to be at the place and time agreed upon with CHCCC staff, with my child and/or myself appropriately dressed and ready;
2. to be ready to receive the return of my child at the time agreed upon with CHCCC staff;
3. to be alcohol/drug free (other than prescribed medications);
4. to hold the staff and CHCCC harmless for damages caused by me or my child while in CHCCC care. Cost for damages incurred will be the assumed responsibility of the child and or parent/guardian or myself.

This consent may be revoked by me at any time except to the extent that action has been taken in reliance thereon. This consent expires upon written request by parent/guardian/legal representative OR one year from the date signed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature Print Name/Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Print Name Date