**FY 2024-2025 Youth Alternatives, Inc.**

**Please indicate interests of the youth being enrolled:**

**Referring Agency/Program:**

**One Graff Street, Oil City, PA 16301 814- 676-5785 Fax: 814- 677-0697**

**1250 Elk Street, Franklin, PA 16323**

**814-346-0188**

### Email: [kids.rule@yavenangocounty.org](mailto:kids.rule@yavenangocounty.01) Executive Director: Corrina J. Woods

**REGISTRATION AND RELEASE FORM**

## REGISTRATION

Name of Youth being enrolled:

Youth's Birth Date: Youth's Social Security Number: \_

# Has the above youth ever been put in placement through CYS, JPO (please circle if yes), or indicate other?

Parents/Guardians

(First & Last Names of ALL Parents/Guardians in Household)

Street City State \_

Zip Code Home Phone Other Phone \_ In case of emergency contact Phone \_ Or contact Phone

# Number of YOUTH in Household: ----

Number of Adults in Household: ----

## LIABILITY RELEASE

Above youth may be participating in Youth Alternatives programs. I acknowledge the risks and potential risks of some Youth Alternative's programs. However, I feel that the possible benefits to me/my son/my daughter ward are greater than the risks assumed. I hereby am intending to be legally bound for myself, my heirs and assigns, executor or administrators, waive and release forever all claims for damages against Youth Alternatives of Oil City, Inc., its board of directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I, my son/my daughter/my ward may sustain while participating in the Youth Alternative program.

Date: Signature:

(youth if 18 yrs. old, otherwise parent or guardian)

## PHOTO REALEASE

I hereby consent to and authorize the use and reproduction by Youth Alternatives of Oil City, Inc., of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, and exhibitions or for any other use for the benefit of the program.

Date: Signature: (youth if 18 yrs. old, otherwise parent or guardian)

**YOUTH ALTERNATIVES, INC.**

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

In the event that emergency aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Youth Alternatives of Oil City, Inc. to:

1. Secure and retain medical treatment and transportation if needed,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

**Name of Enrolled Youth: Phone: Address:**

**In the case that I** **can not be reached, Contact: Phone:**

**or Contact: Phone:**

**Physician's Name: Phone: Preferred Medical Facility: Health Insurance Co.: Policy#:**

**CONSENT PLAN**

This authorization includes x-ray, hospitalization, medication, and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

**Consent Signature: Date:**

(Youth if 18 yrs. old or Parent or Guardian)

**NON-CONSENT PLAN**

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency aid/treatment is required, I wish the following procedures to take place:

**Non-Consent Signature: Date:**

**Printed Name of Person Signing Form: Phone:**

**Additional Health/Medical Comments (if** **Needed):**

The official registration statement and financial information of Youth Alternatives of Oil City, Inc. may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.

7/13/23