TITLE: Youth Client Registration Form Issuing date: 1/23/2007 Revised/effective date: 5/08/2010 Printed: 3/16/2019	
PROCEDURE NUMBER:AF-029 Page 1 of 1	**AGENCY:** Strategic Transitions Consulting SOOAR PO Box 2711; Belleville, MI 48112
Policy approval authority:	Printed or electronic copies of this procedure are uncontrolled and are not considered valid. Copies with executive director signature and or seal are valid.

School/Organization name:

Childs name:_____Age_____ Grade:_____Birthday_____

Parent/Guardian Name:_____

Street Address:_____City/Zip_____

Home Phone:_____ Cell phone:_____

Contact In Case of Emergency:_____ Relation:_____

Home Phone:_____ Cell phone_____

Health Conditions, Allergies, or anything staff should be aware of:_____

Permission to Record and Photograph Child Participating in Activities: I hereby release 'Strategic Transitions Consulting (STC) and Strategies to Overcome Obstacles and Avoid Recidivism (SOOAR) rights to my child's image, likeness, and the sound of his/her voice as recorded or photographed. I understand this recording or photo may be edited and placed in publication, and thereafter the recording or photograph may be otherwise available. I agree to release, discharge, and save harmless the aforementioned agencies including its representatives or designees, from any legal proceedings which may arise in relation to the conditions of the above paragraph.

___ Yes, I give my permission.___ No, I do not give permission. **Parent/guardian Signature:_____ Date:_____**

Permission to Administer Questionnaires to Participants: I hereby give Strategic Transitions Consulting (STC) and strategies to Overcome Obstacles and Avoid Recidivism (SOOAR) permission to administer questionnaires to my child for assessments and the purposes of improving future programs. I understand that the information collected from my child will remain confidential.

___ Yes, I give my permission.___ No, I do not give permission. **Parent/guardian Signature:_____ Date:_____**

Permission to have access to my information: I give the school permission for my child's grades, attendance, and assignments to be viewed and monitored by the facilitators for the purpose of assisting my child in this program.I understand that the information collected on my child will remain confidential.

___ Yes, I give my permission.___ No, I do not give permission. **Parent/guardian Signature:_____ Date:_____**

Waiver of Liability & Permission of Medical Consent: In consideration of Strategic Transitions Consulting (STC) and strategies to Overcome Obstacles and Avoid Recidivism (SOOAR) and the host site of the program, in case of injury, and I am unable to be contacted by your staff, I give my consent to have medical treatment administered to my child if, deemed necessary, by a physician or emergency medical personnel.

Parent/guardian Signature: _____ Date: _____

I clearly understand the objectives and procedures of the program. I understand the benefits of my child participating in this program. I know who to contact if I have any questions. I understand that participating in this program is voluntary and I may withdraw my child at any time. I understand that transportation is my responsibility in order to participate in this program, and that my child must be picked up on time each day that the program is in session. Respect and good manners will be expected at all times; fighting and hitting will not be tolerated. I agree with the above statements and give my consent for my child to participate in this program.

Parent/guardian Signature: _____ Date: _____

NOTE: Recipients of substance abuse prevention services have rights protected by state or federal law and promulgated rules." For information, contact of the Bureau of Health Systems, Division of Licensing and Certification, Substance Abuse Licensing Section, Recipient Rights Coordinator, P.O. Box 30664, Lansing, MI 48909.