

# New York State Young Birders Club Field Trip Registration Form – 2017

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent's Cell Phone \_\_\_\_\_ Student's Cell \_\_\_\_\_

How will student get to and return from these events? (check all that apply) Car Public Transport. Walk

Other (please explain): \_\_\_\_\_

If by car, who will be driving? \_\_\_\_\_ Relationship to student \_\_\_\_\_

I hereby give permission for the above named young birder to participate in the field trips marked "Yes" below of the New York State Young Birders Club (NYSYBC), a program of the New York State Ornithological Association, Inc. (NYSOA). I assume all risks and hazards incidental to the activities of the event and transportation to, from, and during the event. I further release, absolve, indemnify, and hold harmless the New York State Young Birders Club, the New York State Ornithological Association, and all organizers, sponsors, leaders, chaperones, and supervisors of the event. In case of injury, I hereby waive all claims against all organizers, sponsors, leaders, and supervisors. I likewise release from responsibility any person transporting my child to, from, and during the scheduled activities.

Doodletown (Rockland County) 6/4/17 Yes No Will attend 6/11 if 6/4 is cancelled Yes No

**Trip information available at [www.nysyoungbirders.org](http://www.nysyoungbirders.org). Also watch for email updates.**

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## Parent/guardian information & signature (below) required for all participants under age 18

*Note: Parents are encouraged to participate in field trips and other NYSYBC activities!*

### Consent or Non-Consent to Use of Photographs

From time to time throughout the year, an occasion may arise where we would like to publish a photo of the young birder named above in the newspaper, NYSOA and/or NYSOA member club newsletter and/or website, NYSYBC newsletter and/or website, or a similar publication. WE DO NOT IDENTIFY MINORS IN IMAGES ON THE NYSYBC website.

Please **initial** DO or DO NOT: By signing below, I \_\_\_\_\_ DO \_\_\_\_\_ DO NOT give permission to use images of the young birder named above in the manner described.

Name of parent or legal guardian (please print): \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Relationship to student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address (if different from above)

\_\_\_\_\_  
Home/office phone (if different from above)

\_\_\_\_\_  
City, State, Zip (if different from above)

**QUESTIONS?** Email NYSYBC's Adult Coordinators at [ycb@nybirds.org](mailto:ycb@nybirds.org)

**PLEASE FAX to:** (845) 724-3431 **or SCAN/PHOTOGRAPH & EMAIL to:** [ycb@nybirds.org](mailto:ycb@nybirds.org)  
**or mail completed form to:** NYSOA-NYSYBC, PO Box 363, Poughquag, NY 12570

# NYSOA/NYSYBC EMERGENCY MEDICAL AUTHORIZATION FORM - 2017

*(to be submitted ONCE PER YEAR with the FIRST field trip permission form for each calendar year - please print)*

There may be times during a NYSOA or NYSYBC event when minors become separated from their parents. This form is to enable parents and guardians to authorize the provision of emergency treatment for minors who become ill or injured when parents or guardians cannot be reached.

Student Last Name: \_\_\_\_\_ First: \_\_\_\_\_

## **Part I – Contact Information**

Birthdate \_\_\_\_\_ Phone1: \_\_\_\_\_ Phone2: \_\_\_\_\_

### **Residential Parent or Guardian:**

Mother's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Phone1: \_\_\_\_\_ Phone2: \_\_\_\_\_

Father's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Phone1: \_\_\_\_\_ Phone2: \_\_\_\_\_

Other's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Phone1: \_\_\_\_\_ Phone2: \_\_\_\_\_

Name of Relative or other secondary emergency contact:

Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone1: \_\_\_\_\_

Address: \_\_\_\_\_ Phone2: \_\_\_\_\_

## **Part II or III must be completed.**

### **Part II – To Grant Consent**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

### **Part III – Refusal to Consent**

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish NYSOA/NYSYBC authorities to take the following actions:

### **Part IV – Signature**

Date \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

Parent/Guardian's Address \_\_\_\_\_