

# Vipassana Meditation Center

386 Colrain-Shelburne Road, Shelburne, MA 01370-9672  
Tel. (413) 625-2160 • Fax (413) 625-2170  
www.dhara.dhamma.org • info@dhara.dhamma.org

## Parent/Guardian Permission for Teenagers' Course

Course Dates: From \_\_\_\_\_ to \_\_\_\_\_

### Parent/Guardian information:

|                         |                |  |
|-------------------------|----------------|--|
| Name: First (Given)     | Last (Family)  | Phone: Home (     )     -<br>Cell (     )     -<br>Fax (     )     -   |
| Street Address/P.O. Box |                | Age: _____ Gender: M <input type="checkbox"/> F <input type="checkbox"/><br>Date of Birth: Yr _____/Mo ____/Day ____ |
| City                    | State/Province | Zip/Postal Code  |
| E-mail Address:         |                |  |

Relationship to child \_\_\_\_\_

Have you completed a ten-day Vipassana course with S. N. Goenka or one of his Assistant Teachers?  
Yes  No

Will you or another adult remain at the center for the duration of the course? Yes  No

**(Please note: children do not have to be accompanied by an adult)**

If yes, name of adult who will be accompanying your child \_\_\_\_\_

(They will need to send in a Dhamma server's application which is available from the registrar.)

Is there anything we should know about your child that will help him/her to have a successful course (i.e., learning needs, physical or mental health issues, etc.)?

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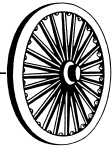
Please be sure to also complete the medical information form included with this package

**My child and I have read the teenagers' course materials (Parent/Guardian Information Sheet, Code of Conduct and Sample Timetable).**

I give my permission for my child, \_\_\_\_\_, to attend this course.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

I am driving to the course and willing to be contacted by others needing a ride: Yes  No



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## Medical Emergency Form and Contact List

### CONSENT FOR MEDICAL TREATMENT

As the parent, agency representative or legal guardian, I hereby give consent to the \_\_\_\_\_ (*center name*) to provide all emergency, medical or dental care prescribed by a duly licensed physician (MD) osteopath (DO) or dentist (DDS)

for \_\_\_\_\_  
Child's name

This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Work \_\_\_\_\_ Work Phone \_\_\_\_\_  
(employer's name)

Father's Work \_\_\_\_\_ Work Phone \_\_\_\_\_  
(employer's name)

**ALLERGIES AND SENSITIVITIES:** Does the child have a history of skin or other untoward reactions or sicknesses following injection or oral administration of:

|  | Circle One | If yes, describe |
|--|------------|------------------|
| a) Penicillin or other antibiotics               | Yes No     | _____            |
| b) Morphine, Codeine, Demerol or other narcotics | Yes No     | _____            |
| c) Novacaine or other anesthetics                | Yes No     | _____            |
| d) Aspirin, Empiricin or other pain remedies     | Yes No     | _____            |
| e) Sulfa drugs                                   | Yes No     | _____            |
| f) Tetanus antitoxin or other serums             | Yes No     | _____            |
| g) Adhesive tape                                 | Yes No     | _____            |
| h) Latex   | Yes No     | _____            |
| i) Iodine or merthiolate                         | Yes No     | _____            |
| j) Any other drug or medication                  | Yes No     | _____            |
| k) Any foods, such as egg, milk or chocolate     | Yes No     | _____            |

**DRUGS TAKEN RECENTLY:** With the past six (6) months the child has taken: \_\_\_\_\_

**CENTER STAFF: PLEASE KEEP THIS FORM WITH YOU WHEN YOU GO TO THE DOCTOR OR HOSPITAL AND NOTIFY THE PARENTS OR GUARDIANS IMMEDIATELY.**

# IDENTIFICATION AND EMERGENCY INFORMATION

**To Be Completed by Parent or Guardian**

|                     |        |        |                |           |     |                |
|---------------------|--------|--------|----------------|-----------|-----|----------------|
| CHILD'S FIRST NAME  | LAST   | MIDDLE | SEX            | TELEPHONE |     |                |
| ADDRESS             | NUMBER | STREET | CITY           | STATE     | ZIP | BIRTHDATE      |
| FATHER'S FIRST NAME | LAST   | MIDDLE | WORK TELEPHONE |           |     |                |
| ADDRESS             | NUMBER | STREET | CITY           | STATE     | ZIP | HOME TELEPHONE |
| MOTHER'S FIRST NAME | LAST   | MIDDLE | WORK TELEPHONE |           |     |                |
| ADDRESS             | NUMBER | STREET | CITY           | STATE     | ZIP | HOME TELEPHONE |

**ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY**

| NAME | ADDRESS | TELEPHONE | RELATION |
|------|---------|-----------|----------|
|      |         |           |          |
|      |         |           |          |
|      |         |           |          |
|      |         |           |          |

**PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY**

|           |         |                       |           |
|-----------|---------|-----------------------|-----------|
| PHYSICIAN | ADDRESS | MEDICAL PLAN & NUMBER | TELEPHONE |
| DENTIST   | ADDRESS | MEDICAL PLAN & NUMBER | TELEPHONE |

**IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?**

----- CALL EMERGENCY HOSPITAL -----OTHER, EXPLAIN:-----  
 -----

**NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY**

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR GUARDIAN)

| NAME                                   | RELATIONSHIP |
|--|--------------|
|  |              |
|  |              |
|  |              |
| <b>SIGNATURE OF PARENT OR GUARDIAN</b> | <b>DATE</b>  |