

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

(This page to be filled out by parent/guardian)

Parent/Guardian Permission for Children's Course

Course Dates: From _____ to _____

Name of Parent or Guardian: _____

Relationship to child: _____

Street Address during the course: _____

Phone # you can be contacted at during the course: _____

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.)?

Does your child have any allergies? Yes No

If yes, please give details on medical information form (included in this package).

Is your child presently taking any medications? Yes No

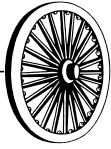
If yes, please give details on medical information form (included in this package).

My child and I have read the children's 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 IMMEDIATEL

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						
<small>(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR GUARDIAN)</small>						
NAME				RELATIONSHIP		
SIGNATURE OF PARENT OR GUARDIAN				DATE		