# TRANSPORTATION CONSENT FORM

YOUTH/CLIENT NAME: _____ DOB: _____
(Print)

_____ OF _____
(Provider's Name) (Name of Provider Agency)

HAS PERMISSION TO PICK UP AND TRANSPORT _____
(Name of Youth/Client)

FROM _____ THROUGH THE TERMINATION OF SERVICES FROM THIS AGENCY.
(Effective Date)

**SPECIAL CONSIDERATIONS/MEDICAL-MEDICATION ISSUES/LIMITATIONS**:

_____

_____

_____

_____ _____ _____
Signature of Legal Guardian Relationship to Youth Date

_____ _____
Signature of Youth (should sign if age 14 or over) Date

**WITNESSED BY**:

_____ _
Print Name of Witness

_____ _____
Signature of Witness Date Witnessed

_____ _____
Agency Address Agency Phone

**EMERGENCY CONTACT**:
Name:_____

Address: _____

State:_____ Zip:_____ Phone:_____

**Unless otherwise specified, this consent will expire 12 months from the date it was signed. This consent or any part of this consent may be canceled at any time with written notification.**