

# **The Rainbow Project**

*“The Promise of a Better Future for Children with Autism”*

## Parent Permission Slip

I hereby give permissions to my child \_\_\_\_\_ to participate in  
Rainbow Project After School Club at the RPLC with supervision of Rainbow Project  
staff.

Parent's name: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Contact Number: \_\_\_\_\_



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## After School Club

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Birth Date: \_\_\_\_dd\_\_\_\_mm\_\_\_\_yy Sex: M / F

Mother's Name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Home address: \_\_\_\_\_

Business address: (Father) \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Business address: (Mother) \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Please specify if your child is taking any medicine: \_\_\_\_\_

On any special diet: \_\_\_\_\_ Allergic to: \_\_\_\_\_.

Programmer will administer first aid. If necessary, the following physician may be called:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_



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**EMERGENCY MEDICAL TREATMENT AUTHORIZATION**

In the event that emergency medical care may be needed and neither we (parents) or guardian can be contacted, I / We hereby authorize Rainbow Project and / or its authorized representative to take my / our child(ren) to Hong Kong Adventist Hospital or other such hospital as may be appropriate under the particular circumstances. I / We agree to hold the project and / or its representative harmless for authorizing treatment and for any costs or expenses resulting from such treatment. I / we also authorize the nearest hospital or clinic, under the particular circumstances, to perform any emergency procedures that are deemed necessary for the emergency treatment of my / or child(ren).

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