



AUTHORIZATION FOR MEDICAL CARE

If it becomes necessary for my child to have medical care while participating in this trip, I hereby give school personnel permission to use their judgment in obtaining medical care for the child, and I give permission to the physician selected by school personnel to render medical care deemed necessary and appropriate by the physician. I understand that the school carries student accidental injury insurance in an amount limited to \$50,000 (applies excess of family health insurance if applicable.)

Student Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent/Guardian Home Phone No.: \_\_\_\_\_

Parent/Guardian Work Phone No.: \_\_\_\_\_

Emergency Contact Phone No.: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian's Name (please print)

\_\_\_\_\_  
Authorized Signature of Parent or Guardian

Date: \_\_\_\_\_

PLEASE CHECK HERE IF INSTRUCTIONS FOR SPECIAL MEDICAL TREATMENT AND/OR OVER-THE-COUNTER MEDICATION FOR THE STUDENT ARE ON FILE IN THE SCHOOL.