

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.