STUDENT/ADULT PERMISSION & MEDICAL RELEASE FORM

Consent to Travel

I, _____, give permission for _____,
(parent or guardian) (name of participant)

to travel with _____ to _____.
(name of organization) (trip destination)

The group will depart on _____ and return on _____.
(departing date) (return date)

In the case of an emergency, please contact _____
(emergency contact and relation to participant)

at _____ or _____.
(phone number) (second phone number)

Consent to Receive Treatment

As parent or guardian of _____,
(name of student)

I authorize treatment of the above mentioned student by a qualified physician or nurse in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual, trained in first aid, if in the opinion of that individual, delay might endanger his/her life, cause disfigurement or undue comfort. On the Medical Information Form I have listed any allergies, ongoing medical treatment, or medical problems which might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Contact Information

Authorized Signature Date

Address

Home Phone

MEDICAL INFORMATION FORM

Student's
Name_____
(First) (Middle) (Last)

Home Address_____
(Street)

City_____ State _____ Zip_____

Home Telephone Number _____ Cell Phone Number _____
(Area code) + (Number) (Area code) + (Number)

Student's date of birth _____ Religion (optional) _____

Medical problems or allergies which might influence medical treatment (If none, please state "none known").

_____

_____

_____

If student is under physician's care for ongoing medical treatment, please complete the following:

Medication(s) _____

Condition _____

Physician's Name_____ Physician's Telephone Number _____

Insurance Information

Name of Primary Insured _____

Primary Insured's Employer _____

Insurance Provider _____

Group Number _____ Member Number _____

***Please copy insurance card and card holders ID on the back of this form or attach to this sheet.