

--- Medical Release Form ---

THIS FORM SHOULD BE COMPLETED AND RETURNED TO YOUR TEACHER

Minor's Name: _____ Date of Birth: _____
 Last _____ First _____ M.I. _____ Mo. /Day/Year _____ SSN. _____
 Parent's Name _____
 Home Address _____
 City _____ State _____ Zip _____ Home Phone _____
 Employer _____ Work _____ Phone _____
 Insurance Carrier Name & Address _____

 Policy No. _____
 Notify In Emergency (if other than parent or guardian) _____ Relationship _____
 Address _____ City _____ State _____ Zip _____ Phone _____
 Family Physician _____ Phone _____
 Allergies _____ Last Tetanus _____
 Medical Problems _____

 Medication Being Used (include dosage/frequency) _____

 Present State of Health _____

AUTHORIZATION FOR TREATMENT OF MINOR

I, the undersigned, parent or legal guardian of _____, a minor, do hereby consent to the nurse or physician selected by the Program Leader or AHSTF to perform routine tests and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by the Program Leader or AHSTF to hospitalize, secure proper treatments for, and to order injection, anesthesia, or surgery for my child as named above.

In the event of any emergencies during the trip to London and Edinburgh this coming _____, the undersigned hereby grants authority to be exercised at the discretion of _____ or chaperone to dispense over-the-counter medication.

Date _____ Signature of Parent/Guardian _____

Please return this form to _____ no later than _____.

PLEASE DO NOT RETURN THIS FORM TO AHSTF.