GLOBAL STUDY CONNECTIONS

Live Your Dream - Study Abroad!

Academic Year 2013-2014 - Authorization to Treat a Minor (a child)

I, the parent or legal guardian of _____, agree to medical treatment for my child. I further authorize any designated agent of _____School to consent to medical treatment for my child. This may include x-ray examination, anesthetic, medical diagnosis, or surgical diagnosis by any medical and emergency room staff licensed under the provisions of the Medicine Practice Act; dentist licensed under the provisions of the Dental Practice Act; or staff of any licensed hospital. This authorization is given in advance of any specific diagnosis, treatment, or hospital care to provide authority for medical care. It is understood that the school and/or medical staff will try to contact me before treatment to the patient, but that treatment will not be withheld if I cannot be reached. I understand that I am responsible for any charges not covered by any accident and sickness insurance policies covering my child.

List any restrictions:

Allergies to drugs or food:

List medications taken regularly:

Birthdate: _____ **Gender: □ Male □Female**

Date of last tetanus toxoide booster: _____

Family Doctor: _____ Phone: _____

Address: _____ City: _____ Country: _____

Parent/Guardian Signature: _____ Date: _____

Address: _____ City: _____ Country: _____

Telephone where Parent/Guardian may be reached:

Business: _____ Home: _____

Email address: _____ Mobile phone: _____