Authorization of Medical Treatment

This form must be completed and signed in order for a student to be able to receive emergency medical treatment in America.

Authorization for Medical Treatment

I/We, _____, the parent(s) or legal guardian(s)

of _____, a visiting international student, authorize the host parent(s) listed below, for the duration of the above named student's stay in the United States of America , to give consent for medical and dental treatment at the most appropriate facility under the care of licensed physicians, surgeons, dentists, orthodontists, or registered nurses, in the event that I/We cannot be contacted. We also agree to pay for the costs of these immunizations or treatments in full.

Student's Name: _____ Date of Birth: _____

Student's School: _____ Grade: _____ Phone Number: _____

Insurance Carrier: _____ ID Number: _____

Signature of Father: _____ Date: _____

Signature of Mother: _____ Date: _____

Signature of Host Mother: _____ Date: _____

Signature of Host Father: _____ Date: _____

Student's Primary Care Physician Contact Information

Name: _____ Work Phone: _____ Cell Phone: _____

Street: _____ City:_____ State:_____ Zip Code: _____

Student's Biological Family Contact Information

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Student's Host Family Contact Information

Name: _____ Home Phone: _____ Cell Phone: _____

Street: _____ City:_____ State:_____ Zip Code: _____

Authorized School Official

Name: _____ Position: _____