Applicant's Name _____

medical **release**

Authorization for Medical Care and Release of Medical Records and Liability

Please read carefully. Sign and date below where indicated.

I/We, the undersigned parent(s)/legal guardian(s) (hereafter *parents*) of the student, and I, the student, if of legal age, hereby authorize the release of medical and dental information in the International Student Medical Form acquired in the course of the examinations by the physician and the dentist. I/We, the parent(s), and the student, who have the sole and legal right to make the decisions on the health and care of the student, do release from liability and grant permission as noted of the following while he/she is overseas as an international student attending _____ (hereafter *school*):

- In the event of accident or sickness, I/we authorize any school staff and/or host parent(s) of the student to select the appropriate medical facility and physician(s)/dentist(s) to provide treatment.
- I/We hereby authorize and consent to any X-ray examination, administration of anesthetic, blood transfusion, surgical operation, or any other medical or surgical diagnosis and treatment rendered under the general or special supervision of any member of the medical staff and emergency-room staff licensed by the state of treatment and/or the provisions of the Medical Treatment Act, or a dentist licensed by the state of treatment and/or under the provisions of the Dental Treatment Act, or staff of any acute general hospital holding a current license to operate a hospital.
- I/We further consent to any medical or surgical treatment by a licensed physician, surgeon, or dentist that might be required by my/our son/daughter for any emergency situation. I/We do request that I/we be notified as soon as possible, but emergency treatment need not be delayed to provide such notice.
- Permission is granted for any additional immunizations that may be required per school and state regulations.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but it is given to provide authority and power to render care which the aforementioned physician or dentist in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. In the case of elective surgery, I/we request that I/we be notified and our permission obtained before such arrangements are made.

I/We agree to hold harmless and release from all liability the school and all staff or all members of the host family for any intervention in an emergency situation regardless of final outcome. I/We agree to assume all financial obligations beyond those covered by health, accident, and sickness insurance for any medical treatment rendered.

Father's/Legal Guardian's Name (please print) _____

Signature (mandatory if student is under age 18) _____ **Date** _____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's/Legal Guardian's Name (please print) _____

Signature (mandatory if student is under age 18) _____ **Date** _____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Student's Name (please print) _____

Signature _____ **Date** _____

Witness' Name (please print) _____

Signature _____ **Date** _____