

MEDICAL RELEASE FORM

DoDDS-EUROPE

Submit signed original and copy with Student Application Form to recommending teacher.
Original **MUST** be carried by student in travel to and from the activity site.

Please print legibly

DATE _____

STUDENT NAME: (Last) (First) (MI)

STUDENT PASSPORT NUMBER/COUNTRY OF ORIGIN

PARENT/SPONSOR (Rank) (Last Name) (First)

ADDRESS(CMR/PSC)

LOCAL HOME ADDRESS (Civilian with local city code)

APO/FPO

*HOME TEL. NO. (Include country and city prefixes)

DSN TEL. NO.

Additional Contact Name (other than your own) _____

Additional Contact Telephone (Include country and city prefixes) _____

Health Insurance Company

Policy # _____ Health Insurance Company Telephone # _____

Insurance Company Address _____

(Circle One) Civilian Insurance Co

Military Insurance

In the event that my dependent, _____, age _____, is injured or becomes ill, I authorize and release the supervising personnel of the activity to take my dependent to any U.S. Medical facility or to any civilian hospital if deemed necessary.

I understand that the above supervising personnel of this activity will use all diligent and responsible efforts to contact me or my spouse. If neither my spouse nor I can be contacted after reasonable attempts by these personnel, or the U.S. medical treatment facility, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize and release any physician or other qualified medical personnel to administer non-emergency care necessary to treat minor injuries or illness of my dependent. I authorize necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastrointestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatment, not including major surgery or procedures involving substantial risk.

My dependent is allergic to: _____

My dependent requires the following medication: _____

Additional Comments: _____

X _____
PARENT/SPONSOR SIGNATURE

SOCIAL SECURITY NUMBER

THIS FORM DOES NOT HAVE TO BE NOTARIZED