MEDICAL AUTHORIZATION FORM

I, the undersigned, and parent or legal guardian of_____and

_____, hereby appoint_____ and

_____, chaperones of The Sister City Exchange Trip as a health care representative, to authorize any and all medical treatment for _____they in their discretion see fit. This includes, but not limited to, treatment to relieve pain.

A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain effect until _____.

MEDICAL INSURANCE COMPANY: _____

MEDICAL INSURANCE ID or GROUP #: _____

MEDICAL INSURANCE CO. PHONE #: _____

PEDIATRICIAN: _____

PEDIATRICIAN PHONE #: _____

EMERGENCY PHONE OR PARENTS #: _____

_____ _____

Signature of Parent/Legal Guardian DATE