

Medical Authorization Form

I, the undersigned, and parent or legal guardian	n ofand
, hereby appoint	: and
, chaperones of The Sister City Exchange Trip as a health care	
representative, to authorize any and all medica	al treatment forthey
in their discretion see fit. This includes, but not	t 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