SAIIE

"Your Life Experience; Your Education"

Medical Consent

Student´s Full Name:_____

Student´s Date of Birth (Month/Day/Year): _____ / _____ / _____

Passport Number: _____

Athletic Program Name (Only if it applies): _____

Term Abroad: _____

I, hereby authorize the diagnosis and treatment by a qualified and licensed medical professional, in the event of a medical emergency where I cannot physically or verbally give authorization because of my injury or illness, which in the opinion of the attending medical professional, requires immediate attention to prevent further endangerment of my life, physical disfigurement, physical impairment, or other undue pain, suffering or discomfort, if delayed. Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the named student. Permission is also granted to the SAIIE staff or anyone belong to their team (professors or guides) to provide the needed emergency treatment prior to my admission to the medical facility. Release authorized on the dates and/or duration of the program. This release is authorized and executed of my own free will, with the sole purpose of authorizing medical treatment under emergency circumstances, for the protection of my life and limb.

This authorization is effective throughout the duration of the program, from

_____ /_____ /_____ to _____ /_____ /_____
(Month) (Day) (Year) (Month) (Day) (Year)

_____ _____/_____/_____
Signature of Participant Student Date

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Student´s Name: _____

Last Name: _____

Please write the student's name and last name in capital letters.
Please make sure to fill out the form as clear as possible.

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods:

_____

Special Medications, Blood Type or Pertinent Information:

_____

_____

_____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____