Brussels American School
Unit 8100 Box 13, APO AE 09714-9998
J.F. Kennedylaan 12, 1933 Sterrebeek, Belgium
Phone: +32-2-717-9552 FAX: +32-2-717-9577

POWER OF ATTORNEY FOR MEDICAL CARE OF DEPENDENTS

I, _____ , the parent or guardian of _____ have granted permission for my child to receive care at the SHAPE Brussels Health Clinic during my absence. In the event of any illness or injury to my child before, during, or after his/her participation in school activities, whether performed at or away from school, if I am not available in the immediate area, I authorize and consent for any treatment, including surgery, deemed necessary by a duly credentialed physician. I hereby grant a POWER OF ATTORNEY to _____. I recognize and agree that in the event a U.S. Government medical treatment facility is unavailable or inadequate to furnish such treatment, my child may be treated in a civilian medical facility and that I may be responsible for the full cost and hold harmless my aforementioned attorney in fact for the costs of any such medical care.

This power of attorney is effective until: _____.

_____ _____

Printed Name of Parent/Guardian Signature Date

Remarks:

_____

_____

Last four numbers of SSN of Parent/Guardian: __-__-__-__

Home Phone:_____

Cell/GSM Phone: _____

Phone numbers for whom you are giving Power of Attorney:

_____