AUTHORIZATION FOR MEDICAL CARE OF DEPENDENT

Robert D. Edgren High School **E. J. King High School** **Nile C. Kinnick High School**
M. C. Perry High School **Yokota High School** **Zama American High School**

In the event that my dependent, _____(full legal name), is injured or becomes ill and needs medical examination or care, while under the supervision of a Department of Defense Dependents schools (DoDDS) employee or while participating in any activity sponsored by a DoDDS Japan District High School (see above), I authorize and release my dependent to care by any U. S. Military Medical treatment facility, or if none are available, by the closest civilian hospital that can provide the required medical care.

DoDDS representatives will use all diligent and reasonable efforts to contact the dependent's legal guardians prior to emergency treatment. If the DoDDS representative and or the military medical treatment facility cannot contact the sponsor or sponsor's spouse after reasonable efforts, I hereby authorize and release the attending physician and/or any other qualified medical personnel to examine my dependent and initiate care for my dependent if necessary. I authorize any emergency care deemed necessary by the attending physician and/or qualified medical personnel for treatment of injuries or illness involving immediate danger of life or limb or possible permanent injury to my dependent. I also authorize non-emergency care as necessary (i.e., suturing lacerations, splinting sprains, casting uncomplicated fractures, treating colds, allergies and minor gastro-intestinal illnesses).

Dependent's Medical Information: (completed by sponsor and reviewed by school nurse)
My dependent has the following medical problems: _____
My dependent is allergic to the following: _____
My dependent is currently taking the following medications: _____
Date of last Tetanus Booster: _____ Date/Location of Sports Physical: _____

Sponsor's Emergency Contact Information: (completed by sponsor)
Full Legal Name: _____ SSN: _____
Mailing Address: _____
Home Telephone: _____ Duty Telephone: _____
Cell Phone: _____ Spouse Duty Telephone: _____
Emergency Contact: (if Sponsor Unavailable) _____
Telephone: _____ Cell Phone: _____

DoDDS Information: The following personnel are authorized to make medical care decisions regarding emergency and non-emergency medical care of my dependent. They are responsible for the physical health of my dependent and are authorized to represent me and approve medical treatment.

_____ _____ _____
Activity Sponsor Activity Chaperone Activity Chaperone

School Nurse_____ School Principal_____

It is my understanding that the DoDDS representative will carry a copy of this authorization letter at practices, rehearsals, when traveling and at games and other competitions (original kept on file with school nurse).

_____ _____ _____ _____
Sponsor Signature Date Spouse's Signature (optional) Date