DEPARTMENT OF DEFENSE
DEPENDENTS SCHOOLS, EUROPE
LAKENHEATH HIGH SCHOOL
MEDICAL RELEASE & POWER OF ATTORNEY FORM
Please print legibly

STUDENT NAME: (Last) (First) (MI)

STUDENT PASSPORT NUMBER AND COUNTRY

DATE OF BIRTH (Day-Month-Year)

U.S. Identification Card: Yes No

Home State and Town:_____

PARENT/SPONSOR (Last) (First)

LOCAL HOME ADDRESS

PARENT HOME EMAIL

STUDENT EMAIL

APO ADDRESS

CELL PHONE NUMBERS(S)

DUTY PHONE NUMBER

HOME PHONE NUMBER

NAME OF HEALTH INSURANCE COMPANY

(Circle One) Civilian Insurance Military Insurance

I, _____, the parent or guardian of _____ grant permission for this child to participate in the Lakenheath High School Athletic Program. In the event that my dependent is injured or becomes ill before, during, after his/her participation in the school activities, whether locally or away, necessitating immediate medical examination or care, I authorize and release the DoDDS-E Coach/Sponsor of this activity to take my dependent to an U.S Medical facility or to any civilian hospital if deemed necessary. I understand that I am responsible for all medical costs, to include ambulance service relating to my dependents injury or illness. The US Government, DoDDS-E, DoDEA and the Department of Defense bear no financial burden related to my dependent's injury or illness with regard to participation in school activities.

I understand the Coach/Sponsor of this activity will use all diligent and responsible efforts to contact me or my spouse. If neither my spouse nor I can be contacted after reasonable attempts by these personnel, or the U.S. medical treatment facility, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize and release any physician or other qualified medical personnel to administer non-emergency care necessary to treat minor injuries or illness of my dependent. I authorize necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastrointestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatment, not including major surgery or procedures involving substantial risk.

My dependent is allergic to:_____

My dependent requires the following medication_____

Additional Information (medical conditions such as diabetes, seizures, asthma, heart and kidney disease, bee stings)

_____

_____ _____

PARENT/SPONSOR SIGNATURE DATE

**This power of attorney is effective through June 2013

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents' absence. ROUTINE USES: (a) To obtain medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDDS employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory. School personnel will not be able to provide emergency medical care and health services in parents' absence.