MEDICAL POWER OF ATTORNEY

SY 2012-2013

In the event that my dependent (NAME) _____ is injured or becomes ill, necessitating immediate medical examination or care/ while under the supervision or while participating in any activities sponsored by _____. I authorize and release to any agent or employee of _____to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of _____will use all diligent and reasonable efforts to contact my spouse or me. If personnel of _____ or the U.S. treatment facility can contact neither my spouse nor me after reasonable attempts, 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 of life or limb of my dependent. I further authorize non-emergency care and necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastro-intestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT (to be completed by parent/guardian) for the purpose of sharing information with teachers and health care personnel on a need to know basis.
My dependent has the following medical problems (such as diabetes, seizures, asthma, heart and kidney disease):

My dependent is allergic to the following: _____

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each medication): _____

_____

Date of last tetanus booster: _____

EMERGENCY CONTACT INFORMATION (to be completed by parent)

Sponsor's Home Address: _____ Home Phone # _____

Sponsor's Name _____ Rank: _____

Sponsor's Unit _____ Work Phone # _____

Spouse's Name _____ Work Phone # _____

Cell Phone #1 _____ Cell Phone #2 _____

Other Names and Phone Numbers to Use in Case of Emergency if Parents/Guardians are Unavailable:

_____

_____

Additional Comments: _____

I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Signature of Parent/Guardian_____ Date _____

Sponsor's Social Security Number _____

Are you a Civilian "Pay Patient"? [ ] Yes [ ] No

PRIVACY ACT NOTICE; AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents'/guardians' absence. ROUTINE USES: (a) To obtain emergency 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 DoDEA employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency regerral. MANADATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory School personnel will not be able to provide emergency care and health services in parents absence.