

MEDICAL CONSENT FORM

In case of an accident or illness:

(Name of student)_____ (Date of Birth)_____

has my permission to receive emergency care of treatment if deemed necessary.

(Home address, including your city and zip code)

(Signature of parent)

(Printed name of parent)

Health Insurance Company

Group or Account Number

(Please attach copy of health insurance card)

Student's Date of Birth _____

Does the student have any existing medical conditions? Yes or No (please circle one)

If you circled yes, please explain further on the reverse side of this form.

Is the student currently using medication? If your answer is yes, please list them here:

Is the student allergic to any medication (s)? _____

Family Doctor _____ ()

(It is hereby understood and agreed upon by Step Higher Program its customers, that Step Higher shall not be held responsible for any claims, losses, suits or actions arising out of acts of God, war, terrorism, strikes, damages or loss of baggage or other personal property, sickness, delay, change of airline flight schedule, or personal injury caused by persons not controlled by Step Higher Program. Tours reserves the right to accept any person(s) as a member of the group, and to pass on to the client any Expenditures created by airline delays or other events not controlled by Step Higher Program such as weather.

*All and any medication will stay in possession with a designated chaperone.