Medical Release Form

Student Name: _____ Age: ____ Birth Date: _____
D/M/Y

Home Phone: _____ Parent Work Phone: _____

Passport Number: _____

Nationality: _____ Expiry Date: _____

Date and Place of Issue: _____

Iqama Number: _____ Date of Issue: _____Expiry Date: _____

Medical Card Plan Name: _____Medical Card Number: _____

Father's Name: _____ Mother's Name: _____

Emergency Phone Number: _____

Name of Emergency Contact Person: _____

Medication

List any medication(s) your child will be taking while traveling

1. _____
2. _____

List any medical problems or allergies that we should be aware of

1. _____
2. _____

AUTHORIZATION FOR MEDICAL TREATMENT

We, the undersigned, authorize any of the following named persons of the American International School-Riyadh to make decisions concerning the medical and/or surgical care of our child.

_____.
(Child's Name)

The following person(s) are authorized and empowered to-wit:

School Nurse, Athletic Director, Team Coach, Advisor, Sponsor _____

All hospitals, clinics or other similar facilities, as well as doctors, nurses, medics, paramedics or other medical personnel may rely on the decisions and authorizations of the above persons concerning whatever medical care or treatment, including surgical procedures, they deem necessary for our child.

EXECUTED THIS _____ DAY OF _____, 20 _____. Effective until June, 2010.

_____ _____
Father's/Guardian's Signature Mother's/guardian's Signature

_____ _____
Print full name of father/guardian Print full name of mother/Guardian