

**ST. CROIX LUTHERAN ACADEMY EXTENDED FIELD TRIP HEALTH CERTIFICATE
PERMISSION FOR MEDICAL CARE AGREEMENT**

Traveler's Full Name: _____
 Date of Birth: _____
 Gender: _____

Destination: _____
 Travel Agency: _____
 Depart Time: _____ Return Time: _____

As parent, guardian or adult of traveler, I hereby give permission for the above named traveler to receive emergency treatment as deemed necessary by a qualified hospital and/or medical physician while on the trip noted above. It is my understanding that St. Croix Lutheran Grades 6-12 does not include health care coverage for this trip and that my health insurance will be used in the event of needed treatment. I further understand that I am fully responsible for any costs incurred for medical attention/services beyond the coverage limits of my health insurance policy, including transportation. I hereby state that the following information is true to the best of my knowledge.

Please Print Clearly and If None, Write None in Each Section

LIST OF ALLERGIES		MEDICATIONS YOU WILL TAKE ON THE TRIP	
LIST PRESENT ILLNESSES		LIST PHYSICAL RESTRICTIONS/ACCOMODATIONS	
PAST SERIOUS ILLNESS/SURGERY		DIETARY RESTRICTIONS/ACCOMODATIONS	
MEDICAL CONTACTS		INSURANCE	
Name		Phone	
Doctor			
Dentist			
EMERGENCY CONTACTS		Health Insurance Carrier:	
Name		Policy Number:	
Parent		Policy Expiration Date:	
Parent		Who Carries Insurance:	
Other		Does it cover outside of MN? Yes No	
Other		Does it cover outside of US? Yes No	

The above-named traveler has my permission to take part in the St. Croix Lutheran Academy trip named above. I agree to and do hereby authorize St. Croix Lutheran Academy, its personnel, and representatives (chaperones), to act for me in any emergency or accident or illness in the event my son/daughter is to receive medical attention if deemed necessary by a professional in the medical field. In the event the traveler named above is unable to participate in the program due to illness or injury, St. Croix Lutheran Academy acting through its personnel or representative is authorized to make whatever arrangements are appropriate in returning the traveler to my care. I understand that St. Croix Lutheran Academy, its personnel, or representatives shall not be responsible for any debts incurred in conjunction with any illness or accident involving my child. I agree to be responsible for such debts as well as any costs incurred for the early return travel for the above named traveler.

Parent Signature

Telephone Number

Date