

**THE AMERICAN BILINGUAL SCHOOL**  
**MEDICAL FORM FOR ATHLETIC PROGRAM**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ CID# \_\_\_\_\_

Address \_\_\_\_\_

Phone# \_\_\_\_\_

Sport Activity \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Mobile: \_\_\_\_\_

Work #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone# \_\_\_\_\_ Mobile: \_\_\_\_\_

Work# \_\_\_\_\_

Other contact person available after 2:45 PM.

Phone# \_\_\_\_\_ Mobile: \_\_\_\_\_

In case of emergency affecting your child, an effort will be made to notify you immediately. In the event we cannot contact you or your representative:

1. What doctor or clinic should we call? Name: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Describe as simply as possible where your doctor, clinic, or preferred hospital is located.

\_\_\_\_\_  
 \_\_\_\_\_

**Medical Alert:**

Does your child have any special health problems the school needs to know about? For example: heart condition, epilepsy, severe allergies, and bee sting reaction.

\_\_\_\_\_  
 \_\_\_\_\_

My child (ward) has my permission to participate in the above-mentioned activity. By signing this form I authorize the coaches or teachers at The American Bilingual School to render first aid to my son/daughter in the event of injury or illness. I also understand that injuries sometimes occur in competitive sports and waive the right of due process against The American Bilingual School or its employees.

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

INTERNATIONAL SCHOOLS ACTIVITIES CONFERENCE  
Medical Release Form

Student's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Home Phone# \_\_\_\_\_

Business Phone \_\_\_\_\_

Passport # \_\_\_\_\_

Nationality \_\_\_\_\_

Father's Name: \_\_\_\_\_

Mother's Name \_\_\_\_\_

**MEDICATION**

List any medication(s) that your son/daughter will be taking while traveling:

1. \_\_\_\_\_

2. \_\_\_\_\_

Please inform us of any medical problems or allergies that we should be aware of:

1. \_\_\_\_\_

2. \_\_\_\_\_

**AUTHORISATION FOR MEDICAL TREATMENT**

The undersigned of \_\_\_\_\_, (parent/guardian) do hereby authorize and empower any of the following persons named below to make any and all 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 coach/sponsor

\_\_\_\_\_

School coach/sponsor

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

EXECUTED THIS DAY OF \_\_\_\_\_ 20 \_\_\_\_\_ Effective until \_\_\_\_\_

\_\_\_\_\_

Father's signature

\_\_\_\_\_

Mother's signature

\_\_\_\_\_

Print full name of father

\_\_\_\_\_

Print full name of mother