

MEDICAL RELEASE AUTHORIZATION

01. STUDENT

LAST NAME: _____ FIRST NAME: _____

COUNTRY: _____ DATE OF BIRTH: _____

We, _____ and _____ natural parents/guardians of the above-named student do herein grant ExchangeMate, its local coordinators, representatives, our child's host family, and school, permission to provide or assist with routine medical treatment, required school physical and immunizations, and medication dispensing. Furthermore, in case of an accident or illness, we give permission for emergency medical treatment to be given to our child, including hospitalization and/or emergency transportation.

We agree to pay all additional expenses that exceed the coverage limit of our child's insurance. We also agree to pay for any treatment, medication, and procedure not covered by the insurance.

This authorization shall be valid for the entire duration of our child's High School Program in the United States.

NATURAL PARENT/GUARDIAN 1:

Full Name: _____

Relationship to student: _____

Signature: _____

Date: ____/____/____

NATURAL PARENT/GUARDIAN 2:

Full Name: _____

Relationship to student: _____

Signature: _____

Date: ____/____/____

AGENT/NOTARY SEAL

