PARENT PERMISSION – RELEASE FORM AND MEDICAL INFORMATION

The parent of each minor need to complete this form
and it is to be brought with the group leader to Jamaica.

Event Name: Jamaica 2008 **Dates:**

*Name*____
*Birth Date*_____________________

Social Security # ____________________________

Address
____

Address
____

Home Phone (____) _______________________

Authorization of Consent to Treatment of Minor:

(*I*) (We), the undersigned, legal guardian(s) of _________________________________ a minor, do hereby release American Caribbean Events (here after referred to as A.C.E.), and/or Marla Day Fitzwater, or the event leaders as agent(s) for the undersigned to consent to medical examination, anesthetic, or surgical diagnosis or treatment, and hospital care when deemed advisable. To be rendered under the general or specific supervision of any physician and surgeon licensed under the Professional Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization being required. But is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his professional judgment may deem advisable.

This authorization is given pursuant to the provisions of the Civil Code of the State of Georgia Release of ***A.C.E.:***

(Guardian's Name)____ shall indemnify, hold free and harmless, assume liability for, and defend *A.C.E.* as agent, servants, employees, officers, and directors from any and all costs and expenses including, but not limited to, attorneys fees, reasonable investigative and discovery costs, court costs, and all other sums which *A.C.E.* have arisen out of
(Student's Name) ____
Use of real or personal property belonging to *A.C.E.*, its agents and servants, employees, officers, and directors, or by actions of omission by
(Student's Name)____.

Guardian Signature: ____

Guardian Signature: ____

Legal Guardian: ______________________________ Phone: _________________________

Other Emergency Contact: _____________________ Phone: _________________________

Family Doctor: _______________________________ Phone: _________________________

Insurance Company: _____________________________________ If None, Please Check ______

Insurance Policy # or Group #:
____

Prescription Medicines taken
____

Known Medical Conditions:
____

____

Allergies:
____

Last Tetanus Immunization
____

Will you allow blood transfusions? YES _______ Initial of Parent/Guardian

NO ________ Initial of Parent/Guardian

Wear Contact Lenses? __________________________

Other:
____

____

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