AUTHORIZATION FOR MEDICAL TREATMENT,
RELEASE AND INDEMNITY AGREEMENT

I am the parent or legal guardian of _____, a minor ("Minor"). Minor is participating in activities provided by i am VolunTourism LLC ("I am VolunTourism"), under the supervision of i am VolunTourism coordinators, staff, volunteers, and/or other chaperoning adults (collectively, " i am VolunTourism Representatives"). I grant this authorization to i am VolunTourism Representatives so that Minor may participate in the activities and so that Minor may receive all appropriate medical attention while in the care of or under the control of or in the possession of, i am VolunTourism Representatives. I understand that i am VolunTourism Representatives will attempt to contact me promptly should Minor require medical attention, but I specifically direct that they obtain such medical care for Minor as they, in their sole discretion, deem advisable.

I hereby grant my consent and authorization to i am VolunTourism Representatives to obtain such medical, dental, psychological and/or surgical treatment for Minor as they in their sole discretion shall deem necessary for the treatment of Minor due to accident or illness.

I understand that i am VolunTourism is providing no medical insurance of any kind, and I agree that my insurance shall be Primary. I assume full responsibility for all bills and charges incurred in the treatment of Minor, and I agree to reimburse and indemnify all expenses incurred on behalf of Minor by i am VolunTourism, i am VolunTourism Representatives and any other agents, employees, sponsors, volunteers, etc.

_____ _____
Signature of Parent or Guardian Printed Name of Parent or Guardian

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for the said County and State, on this _____ day of _____, 20____, within my jurisdiction, the within named _____, who acknowledged that _____ executed the above and foregoing instrument.

_____
NOTARY PUBLIC

My Commission Expires:

[AFFIX NOTARIAL SEAL]

MEDICAL INFORMATION FOR MINOR

Name of Minor_____
Birth Date____/____/____ Age_____ Sex_____
Address_____
City_____State_____Zip_____
Father_____
Home phone (_____)_____ Work phone (_____)_____ Cell phone (_____)_____
Employer_____
Mother_____
Home phone (_____)_____ Work phone (_____)_____ Cell phone (_____)_____
Employer_____
Family Physician_____ Phone (_____)_____

Other person to contact in case of emergency:
Name_____
Home phone (_____)_____Work phone (_____)_____ Cell phone (____)_____
Employer_____

HEALTH HISTORY

Check if Minor has had:
___ear infections ___dietary restrictions* ___chicken pox ___measles
___heart trouble* ___ asthma* ___diabetes ___other*
___operation or serious health problem*
* Explain in detail below:

Please explain or list existing medical conditions:

Check if Minor is allergic to:
___bees/insect bites ___penicillin ___other drugs ___foods
Please explain or list additional allergies below:

List medications Minor is currently taking, including, vitamins. (Prescription medicines MUST have pharmacy label and name of doctor.)
Medications:

Date of last tetanus booster: _____ (If you don't know the date but you know this booster is up-to-date, please write "current". If the booster is not up-to-date please speak with your family physician.)

This history is correct as far as I know. Camper has permission to engage in all activities except (list prohibited activities):

Please provide information concerning any insurance benefits for which your child is eligible.
Insurance carrier_____Phone_____
Address_____
Policy #_____
Group #_____