

MEDICAL POWER OF ATTORNEY

Vilseck HS Robotics Camp

Vilseck, Germany

Name of Student: _____

In the event that my dependent (NAME) _____ is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision or while participating in any activities sponsored by Vilseck High School, Unit 28041, APO AE 09112, I authorize and release to any agent of Vilseck HS, to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the personnel from Vilseck HS will use all diligent and reasonable efforts to contact my spouse or me. If personnel of Vilseck HS or the U.S. treatment facility can contact neither my spouse nor me after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger of life or limb of my dependent. I further authorize non-emergency care necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastro-intestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT (to be completed by parent)

My dependent has the following medical problems (such as diabetes, seizures, asthma, heart and kidney disease):

My dependent is allergic to the following:

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each medication): _____

EMERGENCY CONTACT INFORMATION (to be completed by parent)

Sponsor's Name: _____

Sponsor's Home Address: _____

Home Phone Number (Full Area Code): _____

Sponsor's Work Phone # _____

Sponsor's Mobile Phone: _____ Other Contact Number: _____

Sponsor's Unit or Agency: _____

Other Names and Phone Numbers to Use in Case of Emergency if Parents are Unavailable:

Signature of Parent _____

Date: _____

Medical Record Social Security Number _____ Student's Social Security Number _____

Are you a Civilian "Pay Patient"? _____ Yes _____ No

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by ACE VBC Agents and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory