MEDICAL TREATMENT CONSENT FORM

Group Name: Bailey MS Band **Trip ID:** 14083A

Destination: Boston, MA **Trip Date:** 04/20/2016

Tour Participant Name: _____

Parent/Guardian Name(s): _____

Permanent Address: _____

The above named tour participant is covered by insurance: **Yes** ☐ **No** ☐

Primary Parent/Guardian Contact	**Secondary Contact** *(If parent/guardian listed to the left is unavailable, list the person who would be authorized to make medical decisions for the tour participant.)*
Name: _____	**Name:** _____
Relation to tour participant: _____	**Relation to tour participant:** _____
Home Phone: _____	**Home Phone:** _____
Cell Phone: _____	**Cell Phone:** _____

MUST BE COMPLETED BY PARENT/LEGAL GUARDIAN

If you wish, please use the space below to share any information regarding the medical history of the above named tour participant that would be critical in the event of an emergency.

MEDICAL TREATMENT CONSENT FORM

Group Name: Bailey MS Band **Trip ID:** 14083A

Destination: Boston, MA **Trip Date:** 04/20/2016

Tour Participant Name: _____

MUST BE COMPLETED BY PARENT/LEGAL GUARDIAN

All parents/guardians of Scholastica Travel tour participants must carefully read and sign the following. Your signature indicates that you understand and agree, for yourself and for _____ (tour participant's name), to the permissions, acknowledgements of your (and your child's) responsibilities and waivers of liability below.

I authorize the chaperones and Independent Tour Leaders to seek emergency diagnostic or medical treatment or care as needed by student while participating in a Scholastica Travel Inc. tour. I understand that whenever possible, the chaperones and Independent Tour Leaders will make a good faith effort to contact me prior to such treatment or care; if this notification is not feasible under the circumstances, I understand that the chaperones and Independent Tour Leaders will notify me as soon as possible of any diagnosis made and/or treatment or care provided.

I consent to such emergency diagnostic or medical treatment or care of student, in any setting, as may be deemed necessary by a licensed health care provider. I understand that there are unpreventable risks to any person who receives emergency diagnostic or medical treatment or care, including without limitation serious bodily injury or death. I understand that Scholastica Travel Inc. cannot and does not assume responsibility for, nor do they have any liability for, the medical assistance and care that may be so selected and provided.

I understand it is not and shall not be the responsibility of chaperones and Independent Tour Leaders, or Scholastica Travel Inc. to file insurance claims or pay for such emergency diagnostic or medical treatment or care hereunder. **I accept responsibility for payment for any and all such treatment or care.** I authorize any medical office or healthcare facility that renders such treatment or care to release medical information necessary for the processing and payment of related insurance claims. I hereby assign my rights (if any) to receive payment for, and authorize the payment of insurance claims directly to, any healthcare provider or healthcare facility that renders such treatment or care.

I hereby release Scholastica Travel Inc, chaperones and Independent Tour Leaders from any costs, expenses or liabilities (including without limitation attorneys fees and other costs of litigation) arising out of or resulting from the need to obtain emergency medical care or my student's failure to follow all medical treatment and medication policies.

Signature of Parent/Legal Guardian_____

Print Name: _____ **Date:** _____