

AUTHORIZATION FOR MEDICAL CARE OF DEPENDENT

In the event that my dependent _____ (full legal name) is injured or becomes ill and needs medical examination or care, while under the supervision of a Department of Defense Dependents Schools (DoDDS) employee or while participating in any activity sponsored by a DoDDS Japan District high school (see above), I authorize and release my dependent to care by any U.S. military medical treatment facility, or if none are available, by the closest civilian hospital that can provide the required medical care.

DoDDS representatives will use all diligent and reasonable efforts to contact the dependent's legal guardians prior to emergency treatment. If the DoDDS representative and or the military medical treatment facility cannot contact the sponsor or sponsor's spouse after reasonable efforts, I hereby authorize and release the attending physician and/or any other qualified medical personnel to examine my dependent and initiate care for my dependent if necessary. I authorize any emergency care deemed necessary by the attending physician and/or qualified medical personnel for treatment of injuries or illness involving immediate danger of life or limb or possible permanent injury to my dependent. I also authorize non-emergency care as necessary (i.e., suturing lacerations, splinting sprains, casting uncomplicated fractures, treating colds, allergies and minor gastro-intestinal illnesses).

Dependent's Medical Information (completed by sponsor and reviewed by school nurse). My dependent has the following medical problems:

My dependent is allergic to the following: _____

My dependent is currently taking the following medications: _____

Date of last Tetanus Booster: _____ Date/Location of Sports Physical: _____

Sponsor Emergency Contact Information (completed by sponsor)

Full Legal Name: _____ SSN: _____

Home Telephone: _____ Duty Telephone: _____

Cell Phone: _____ Spouse Duty Telephone: _____

Emergency Contact (Sponsor unavailable): Name: _____

Telephone: _____ Cell Phone: _____

DoDDS Information. The following personnel are authorized to make medical care decisions regarding emergency and non-emergency medical care of my dependent. They are responsible for the physical health of my dependent and are authorized to represent me and approve medical treatment.

Activity Sponsor

Chaperone

Chaperone/Activity Sponsor

School Nurse

School Principal

It is my understanding that the DoDDS representative will carry a copy of this authorization letter at practices, rehearsals, when traveling and at games and other competitions (original kept on file with school nurse).

Sponsor Signature

Date

Spouse Signature (optional)

Date