



Consent to Treat Form

This is to certify that on this date, I _____, as parent or guardian of _____, (trip participant), give my consent to Nord Anglia Education, all Nord Anglia Education affiliated schools, and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury or illness that could arise from participation in Nord Anglia Education events. **All charges incurred for any medical expenses for treatment/services rendered NOT covered by guardian/student health insurance will be billed to the students account accordingly.**

If said participant is covered by any insurance company, please complete the following:

Insurance Company: _____

Policy Number: _____ Group Number: _____

Type of Policy: **PPO** **HMO** **Other:** _____

Insurance Company Phone Number: _____

EMERGENCY CONTACTS:

1. Name: _____ Relationship: _____
Cell Phone: _____ Email: _____
Address: _____

2. Name: _____ Relationship: _____
Cell Phone: _____ Email: _____
Address: _____

Physician's Name: _____ **Phone:** _____

Do you have any medicine allergies? Yes No If Yes, which medicine(s) _____

Have you had a recent tetanus booster? Yes No If Yes, when? _____

Are you currently taking any medications? Yes No If Yes, please list all medications.

Has a doctor placed any restrictions on your activity? Yes No If Yes, please explain.

Signature of Parent/Legal Guardian (please type name)

Date