# Medical Form & Healthcare Proxy
*for Student / Youth Tour Participants*

COLD SPRING HARBOR HIGH SCHOOL
82 TURKEY LANE COLD SPRING HARBOR NY 11724 631-367-6834
Washington D C 4 days - 5/22/2017

Participant Name _____

Date of Birth _____ Participant Cell Phone # _____

Address _____

Town _____ Zip _____

Home Phone with area code _____

Father's Name _____ Cell Phone # _____

Mother's Name _____ Cell Phone # _____

Medical Insurance Company _____ **AND** Policy Number _____

Family Doctor _____ Phone Number _____

State any allergic reactions to medications or serious food/environmental issues: _____
_____

State any medications being brought on the trip, including dosage and schedule: _____
_____

State any pertinent medical history needed in the event of a medical emergency: _____
_____

Other Emergency Contacts and Phone Numbers:

1) Name _____ Phone Number _____

Relationship _____

2) Name _____ Phone Number _____

Relationship _____

In the event emergency medical treatment is needed for my child, I _____ (parent/guardian) of _____ (insert student name) hereby give permission to the physician selected by the directors or their authorized representatives, to hospitalize, secure treatment for, and to order injection, anesthesia, or surgery for my child as named above, at my sole cost and expense. I waive any and all recourse against COLD SPRING HARBOR HIGH SCHOOL and Fantastic Tours & Travel or it's authorized representatives; the whole in accordance with the general conditions stipulated in the application for enrollment. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parent's Signature _____ Parent's Name (print)_____

Tour member's signature required if 18 years or older _____