GRAND College TOURS

Medical Release

Student Information

First Name______________________ Middle Name_____________ Last Name___________________________

Date of Birth _____/______/______ ____ Male ____ Female

Home Address____

City ____________________________________ State ________ Zip ________________________________

Home Phone: (   ) ______________________ Cell Phone: (   ) ____________________________

Email:____

Emergency Information

Name____ Relationship ______________________________

Home Phone: (   ) ______________________ Cell Phone: (   ) ____________________________

Name____ Relationship ______________________________

Home Phone: (   ) ______________________ Cell Phone: (   ) ____________________________

Medical Information

Physician _____________________________________ Phone: (   ) ______________________________

Insurance Company Name ____

Insurance Policy Name and Number____

Know Medical Conditions and/or Restrictions ____

____

Medications ____

Allergies (drug, food, other)____

Other Information we should know ____

____

Authorization of Consent to Treament of Minor

(I) (We), the undersigned, parent(s)/legal guardians of ________________________________, a minor, do herby authorize Grand College Tours/Grand Edventures, Inc., for and on behalf of the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office or said physician or at a hospital, during all times that the Minor is in the presence of Grand College Tours/Grand Edventures, Inc.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hosptial care being required, but is given to provide authority and power on the part of our aforesaid Grand College Tours/Grand Edventures, Inc. to give specific consent to any and all such diagnosis, treatment, or hospital care which the afore-mentioned physician in the exercise of his best judgement may deem advisable.

I also agree that I will be fully responsible for the cost of medical treatment and any related transportation or costs. This authorization is in affect for the complete tour dates.

Student's Signature ____ Date_____________

Parent's/Legal Guardian Signature ____ Date_____________

GRAND College TOURS

Mail to: Grand Edventures, Inc. P.O. Box 970694, Boca Raton, FL 33497
(954) 354-1080

www.grandcollegetours.com