Parental Consent & Authorized Medical Consent Form

Child's Full Name _____

Birthdate _____

Last 4 numbers of Social Security # _____

Home Address _____

Home Phone _____

Parental Consent for International Travel

I/We, the undersigned, parent(s) of _____, a minor, do hereby consent to said minor participating in **the summer PNW trip** conducted by **The Lindsborg Swedish Folk Dancers** between June 19th, 2025 and June 25th, 2025.

Parent/Legal Guardian_____ **Date** _____

Parent/Legal Guardian_____ **Date** _____

Authorization of Consent for Treatment of Minor

I/We, the undersigned, parent(s)/guardian(s) of _____, a minor, do hereby authorize **The Lindsborg Swedish Folk Dancers Directors**, hereinafter "Agent", 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 of said physician and/or at a hospital, during all times that the Minor is in the presence of said Agent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid Agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of their best judgment may deem advisable, and release Agent from all damages of same.

This authorization shall remain effective through the 25th day of June, 2025, unless sooner terminated in writing.

Parent/Legal Guardian_____ **Date** _____

Parent/Legal Guardian_____ **Date** _____

_____

Signature **Date** **My Term Expires**
Notary Public of the State of Kansas

Emergency Medical Release Form - Lindsborg Swedish Folk Dancers
In Effect for June 19th-June 25th, 2025

Name

Parent's Name Home Phone

Home Address Cell Phone

Emergency Contact Phone

Second Emergency Contact Phone

Name of Family Physician Phone

Allergy Information, if allergic to any drugs (penicillin, insulin, etc.) Please specify.

Date of last tetanus: Rheumatic Fever Y – N Diabetes Y – N Epilepsy Y - N

Surgery(s) within the last year:

Is the student under medical treatment at the present time? Y – N If yes please explain,

List <u>ALL</u> medications student is currently taking (prescription and over-the-counter)
Medication/s

List any health information/conditions helpful in properly caring for this student.

Health Insurance Information (please enclose a copy of the card)

Insurance Company Name: Policy Number:

Name under which policy is listed:

I give permission for treatment of this student by a physician and/or hospital for any medical or surgical emergency and/or illness.

Signature of Parent or Legal Guardian **Date**

Signature of Parent or Legal Guardian **Date**

Signature **Date** **My Term Expires**
Notary Public of the State of Kansas