

MEDICAL POWER OF ATTORNEY

In the event that my dependent _____, is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision or while participating in any activities sponsored by DoDDS, I authorize and release to any agent or employee of DoDDS, to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above personnel of DoDDS will use all diligent and reasonable efforts to contact my spouse or me. If neither my spouse nor I can be contacted after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger of life or limb of my dependent. I further authorize non-emergency care necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastro-intestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT

My dependent has the following medical problems (such as diabetes, seizures, asthma, heart and kidney disease):

My dependent is allergic to the following:

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each medication): _____

Date of last tetanus booster: _____

EMERGENCY CONTACT INFORMATION (to be completed by parent)

Sponsor's Home Address _____ Home Phone # _____

Sponsor's Name _____ Rank _____

Sponsor's Unit _____ Work Phone # _____

Spouse's Work Phone # _____

Other Names and Phone Numbers to Use in Case of Emergency if Parents are Unavailable:

Additional Comments:

I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Date _____ Signature of Parent _____

Medical Record Social Security Number _____ Student's Social Security Number _____

Are you a Civilian "Pay Patient"? _____ Yes _____ No

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDDS employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.