



Pope John Paul II High School
International Student Program
2020-2021 SCHOOL YEAR

LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE

TO WHOM IT MAY CONCERN:

I, _____ (natural parent or legal guardian), hereby give

Print

permission that my child, _____

First

Middle

Last

may be given emergency treatment to include first aid and CPR by a qualified emergency medical or first aid caregiver. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

 Parent/Guardian Signature

 Date

 Witness Signature

 Date

List any allergies and medications for medical personnel to be made aware: _____

Medical Insurance Company: _____

Policy/Membership Number: _____ Group Number: _____

Policy Holder Name: _____ Student Date of Birth: _____

JPII AND HOST INFORMATION

Emergency number: (360) 951-5408 Mrs. Therese Allin, Principal

Authorized Host Family: _____

Host Address: _____ Host Phone: _____

