ADMINISTRATIVE GUIDELINE (Policy 800.33)
PARENT/GUARDIAN RELEASE FORM
INTERNATIONAL TRAVEL

RELEASE

My/our son/daughter has permission to take part in the Lake Country School District Field Trip to France in April, 2006.

I/we agree to, and hereby authorize, Lake Country School District, its personnel and representatives (chaperones), to act for us in any emergency, accident or illness in the event my/our son/daughter requires medical attention if deemed necessary by a professional in the medical field.

In the event my/our son/daughter is unable to continue participating in the program due to illness or injury, the Lake Country School District, acting through its personnel or representatives, is authorized to obtain medical treatment and/or release my/our son/daughter is my/our personal care and make whatever arrangements are appropriate under the circumstances.

The Lake Country School District, et al., its personnel or representatives, shall not be responsible for any debts incurred in conjunction with any illness or accident, and I/we agree to be responsible for such debts as well as for any costs incurred for the early return travel for my/our son/daughter.

I/we agree to be responsible for and to pay any/all bills for medical, optical, dental or related services whether or not such services are covered by insurance. Should such bills be paid by Lake Country School District, et al., its personnel or representatives due to emergency or otherwise, I/we agree to repay such amounts promptly to the party who made the payment. I/we recognize that the school district recommends that we have adequate medical and hospital insurance coverage while abroad according to a policy or policies currently in force. The policies will continue in force for the entire program.

I/we affirm that the information stated in the Certificate of Medical Insurance Care and Release form. We also recognize that we are responsible for any costs incurred that are medical, optical or dental and their related expenses.

I/we fully understand that we must have fully disclosed all medical/dental issues that could impact/affect our student's medical/dental/emergency care.

_____ _____
Signature of Parent/Guardian Date

_____
Street Address City State Zip

_____
Phone Number (s)

_____
Medical Insurance Company Policy/Group #

_____
Dental Insurance Company Policy/Group #

_____
Student's Physician (please print name) Phone