

**AUTHORIZATION OF MEDICAL OR SURGICAL
CONSULTATION/TREATMENT**

For and in consideration of the grant of permission

by _____ (organization's name)

for _____ (participant's name)

to participate in the _____ Program of _____
(organization's name), the undersigned hereby authorizes _____
and designated representatives thereof to grant permission for the medical and surgical treatment of said student
during the participation of Student in the aforementioned _____ Program.

Although the undersigned understands that when possible advance permission of the undersigned will be sought
for any necessary surgical treatment, the undersigned agrees that any and all medical treatment and surgery may
be performed when, in the opinion of competent medical authorities, the health or welfare of the Student will be
adversely affected by any delay. It is understood that such permission may be required by law of the country the
Student is visiting.

SIGN ONLY IN PRESENCE OF NOTARY PUBLIC

Signature Date

State of _____

County _____

On _____

Before me _____ (insert name and title of the office)

personally appeared _____ (insert name of student)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is
subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized
capacity and that by his/her signature on the instrument the person, or the entity upon behalf of which the person
acted, executed the instrument.

WITNESS my hand and official seal.

Signature of Notary Public