MEDICAL RELEASE
and PERMISSION FOR EMERGENCY MEDICAL TREATMENT

I, ____________________________ [printed name], approve release of this Health Report (inc. all forms) to the administrators and representatives of the Academic Program in the Adirondacks (APA). This includes my Hamilton Off-Campus Study Health Screening Form, Confidential Physician’s Report, and Counselor’s Report (if any). In the event that I require medical care during my semester off-campus, I authorize the APA general director to contact my parent(s) or legal guardian. In this event, I further authorize the release by APA of my medical records and other information regarding my health status to health care professionals responsible for my care, my parent(s), or other designated contact persons, as well as authorized individuals on my home campus.

In the event that I am unable to give consent to medical care myself during an emergency, and/or my parents/guardians cannot be reached in a timely manner, I hereby give to the APA general director, faculty-in-residence, or a duly appointed representative consent to care for me, including consent to make decisions for medical and surgical treatment and hospitalization.

I attest that I have fully and honestly disclosed, to the extent of my knowledge, all/any medical or emotional conditions for which I am currently being treated or have been treated in the past 3 years. Further, I acknowledge that any knowing failure to provide accurate and complete information on the medical record form that endangers my well-being and/or proves disruptive to the program may result in my dismissal from the program.

I agree to notify APA in writing of any changes in my health that may occur prior to the start of the program.

Student Signature
_________________________________________
Date ______________________

PARENT OR LEGAL GUARDIAN ACKNOWLEDGEMENT

I, ____________________________, [printed name], the parent or legal guardian of ____________________________, have reviewed and discussed this medical release and permission for emergency medical treatment form with my child/ward.

Parent/Legal Guardian Signature
_________________________________________
Date ______________________