



AMIE Medical Information & Release Form (v1.0)

To be completed by a Parent/Guardian of the Trip Participant.

The following medical and contact information may be necessary in the unlikely event of an illness or accident. The facts you disclose will be kept confidential and will only be used by the home office and the program staff in the field to respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness.

Section I: AMIE Participant's Information

First name	
Last name	
Address	
City/State/Zip	
Country	
Telephone	
Email address	
Date of birth (mm/dd/yyyy)	

Section II: Emergency Contact Information

Name of CUSTODIAL parent/guardian (this is the person we will contact first in case of emergency)	
Relationship to participant	
Daytime telephone	
Alternate telephone	
Email address	
Name of SECOND parent/guardian	
Relationship to participant	
Daytime telephone	
Alternate telephone	
Email address	
Name of ALTERNATE emergency contact person	
Relationship to participant	
Daytime telephone	
Alternate telephone	
Email address	

Section III: Medical & Dental Insurance Information

Please provide your medical and dental insurance policy information below.

If your daughter is traveling overseas during this program, please make sure your medical insurance company will provide coverage while she is in another country and will provide coverage for her medical emergency return (in the event of serious illness, accident or injury during the program).

If your current insurance company will not cover your daughter's medical expenses while overseas or provide for her return, please make arrangements with another insurance company for coverage during the program.

If you have any questions, please contact us.

I have checked with my medical insurance company. My daughter is covered, as required above, for the duration of her exchange program as well as providing for her emergency return.

Medical insurance plan name	
Policy number	
Group policy number	
Insurance plan telephone number	
Address to file medical claims	
City/State/Zip	
Country	
Physician's name	
Physician's telephone number	
Dental insurance plan name	
Policy number	
Group policy number	
Insurance plan telephone number	
Address to file dental claims	
City/State/Zip	
Country	
Dentist's name	
Dentist's telephone number	

Section IV: Personal Information

Please provide detailed information about any condition that could restrict your daughter's participation in activities or possibly require treatment during the program. If your daughter is traveling overseas, please indicate information that could impact the home chosen for her stay.

Allergies <ul style="list-style-type: none">List all allergies or indicate noneDescribe the allergic reaction and management of each reaction	
Medication allergies	

Food allergies	
Other allergies (insect stings, hay fever, etc.)	
Vision	
Does your daughter wear eyeglasses or contact lenses? (If yes, please specify)	
Do you have an extra/spare set that can travel with her?	
Do you have a copy of her vision prescription?	
Medications	
Does your daughter take any type of prescription or over-the-counter medication? (If yes, please specify names and doses)	
Does your daughter need supervision when taking her medication?	
Blood type	
What is your daughter's blood type/RH factor?	
Additional information	
Is there any other medical, dental or personal information you would like us to know? (If yes, please specify)	

Food restrictions

My daughter **does not eat**: red meat pork poultry seafood dairy products other (please specify) _____

Activity restrictions

My daughter **does not** have medical/physical conditions that limit or restrict her physical activities.

My daughter has a medical/physical condition that limits or restricts her physical activities. Please specify: _____

Section V: Parent/Guardian Authorization

I verify that the above information is true and correct, to the best of my knowledge. My daughter has permission to participate in all program activities except as noted.

I hereby give permission to American-Moroccan International Exchange (AMIE) to seek emergency medical treatment including ordering x-rays or routines tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is understood that in case of an emergency, AMIE will make every reasonable attempt to immediately contact this participant's parent(s) and/or guardian(s). In the event I cannot be reached in an emergency, I hereby give permission to the

licensed physician selected by AMIE to secure and administer treatment, including hospitalization, injections, anesthesia or surgery, for my child.

Signature of Parent/Guardian _____

Printed Name _____

Date _____

For More Information

If you have any questions, please contact us at info@amieonline.org

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USA

Phone from the US – 1.425.427.5799

Phone from Morocco – 00.1.425.427.5799

Fax completed form to AMIE (US): 1-207-470-5799