**Child's Information:**

1. **Child's Full Name:**
   * Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Passport/ID Number (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Travel Details:**

1. **Travel Destination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Departure Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Legal Guardian Information:**

1. **Parent/Legal Guardian 1:**
   * Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Contact Number (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Contact Number (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Parent/Legal Guardian 2 (if applicable):**
   * Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Contact Number (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Contact Number (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorized Adult Traveling with the Child:**

1. **Authorized Adult's Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Contact Number (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Contact Number (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Information:**

1. **Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Current Medications (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Existing Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent for Medical Treatment:**

I, the undersigned parent/legal guardian of the above-named child, hereby grant permission for the authorized adult listed above to seek and consent to necessary medical treatment for my child in the event of an emergency during the specified travel dates. This includes, but is not limited to, medical examinations, surgical procedures, and administration of medication.

**Additional Instructions (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Photocopy of Insurance Card Attached:**

* Yes
* No

**Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness (if available):**

**Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**