



CONSENT TO TREAT TRAVELERS

Please print all information

I, _____, self or legal guardian of _____, born _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for my welfare or my child's while under the care of Elizabeth Pijanowski, Carolina Beloso and I am not reasonably available to give consent.

This authorization is effective from April 3rd, 2026 to April 10th, 2026.

Signature of Self, Parent or Legal Guardian

This consent form should be taken with the traveler to the hospital or physician's office when the traveler is taken for treatment.

This additional information may assist in treatment if provided with consent, but it is not required.

Emergency Contact _____
Phone Number _____ Email _____

Birthdate _____ COVID Vaccine? Yes _____ No _____
Allergies to drugs or foods _____

Special Medications, Blood Type or Pertinent Information

Physician _____ Phone _____
Insurance _____ Policy # _____
Group # _____ Phone # _____



ALLERGIES AND MEDICATIONS
Please print all information. If none please write N/A

STUDENT/PARTICIPANT'S NAME: _____

PLEASE LIST ALL ALLERGIES:

Allergy to: _____ Reaction: _____

PLEASE LIST ALL THE MEDICATIONS THE STUDENT/PARTICIPANT IS TAKING:

Medication: _____ For: _____

Dosage: _____ Frequency: _____

Medication: _____ For: _____

Dosage: _____ Frequency: _____

Medication: _____ For: _____

Dosage: _____ Frequency: _____

I, (Parent/Guardian name) _____

Authorize Elizabeth Pijanowski & Carolina Belloso

to dispense the above medications to my child during the travel period between:

April 3rd, 2026 and April 10th, 2026.

Parent/Guardian Signature

Date