

Dental Examination

YOUTH EXCHANGE STUDENTS NAME -- Send a copy of this page of YOUR LONG-FORM APPLICATION

Full legal name of applicant

To the Dentist: This student is considering a year abroad as an exchange student. Insufficient, inadequate or improper information about a student relative to dentition, medications, or other problems could put the life of this student in danger while overseas. The Dental Examination may **not** be completed by an immediate relative of the student. *Please type or print this form.*

This certification is to be signed by the student's dentist. Please note the general state of dentition and note any dental problems which may occur and which may require attention while the applicant is in another country.

1. Is the applicant in good dental health? Yes No
2. Does the applicant require dental work at this time? Yes No
3. Do you foresee the applicant requiring any dental work while abroad? Yes No (If "Yes," explain on reverse)

CERTIFICATION: I certify that the applicant's dental condition is as noted above. I certify that I am not an immediate relative of the patient and hold a valid license to practice dentistry.

Jose Dentise	*		123-456-7890
Type - Dentist's Name	Signature	Date (yr/mo/day)	Telephone

Permission for Medical Care and Release of Medical Records and Liability

1. We, the parents/guardians of the applicant, and I the applicant, hereby **authorize the release of medical information** acquired in the course of the examination by the physician and dentist.
2. We, the parents/guardians of the applicant, and the applicant if of legal age, who have the sole and legal right to make the decisions on the health and care of the applicant do **release from liability and grant permission** as noted of the following while our son/daughter/ward is overseas as a Rotary Youth Exchange student:
 - 1 In the event of **accident or sickness** we/I authorize any Rotarian, authorized chaperones of Rotary activities and host parent(s) of our son/daughter/ward to **select the appropriate medical facility and physician(s)/dentist(s)** to provide treatment;
 - 1 We/I give permission for any operation, administration of anesthetic or blood transfusion which a medical practitioner may deem necessary or advisable for the treatment of our son/daughter/ward;
 - 1 We/I further **consent to any medical or surgical treatment by a licensed physician, surgeon or dentist** which might be required by our son/daughter/ward **for any emergency situation**. We do request that we be notified as soon as possible, but emergency treatment need not be delayed to provide such notice. Permission is granted for immunizations required for school registration;
 - 1 In the case of **elective surgery**, we/I request **that we/I be notified prior** to such arrangements.
3. We/I agree to hold **harmless Rotary International, any Rotary District, Rotary Club, Rotarian, Rotary chaperone, host family, physician/dentist and medical facility for any intervention in an emergency situation** regardless of final outcome.
4. We/I agree to **assume all financial obligations** beyond those covered by insurance for any medical treatment rendered.
5. We/I further **release Rotary International, all Rotary Districts, Rotary Clubs, Rotarians and host parents from damages arising out of ordinary negligence**, excepting gross negligence or intentional conduct, during the time they may be providing care and control of our son/daughter/ward.

YOUR FATHERS NAME

MOTHERS & STUDENTS NAME

Type - Father/Guardian name

Type - Mother/Guardian name

Type - Applicant name

*
Signature

*
Date (yr/mo/day)

*
Signature

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Date (yr/mo/day)

*
Signature

*
Date (yr/mo/day)

Emergency Contact in home country

FRIENDS NAME

Name

Relation to you

Telephone

Fax

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