GO TREK, INC.
Authorization of Emergency Treatment of Minors in Absence of Parent or Guardian

Name of Minor: ____
Age: ___________ Birth Date: ________________________(mm/dd/yy)
Phone: ___________________________

I, the undersigned, being the parent or legal guardian of the above-named minor know that since I will not be on the trip I will not be available to authorize medical, dental, surgical care and hospitalization for said minor, and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is meant to give the persons named below the right to give consent to authorize emergency diagnostic procedures, as well as medical, dental, and surgical care and hospitalization. This authorization is intended to give consent for the authorization of any such care that the below named persons deem advisable in which the treating physician, dentist, orthodontist, or hospital personnel may deem advisable.

If there are important medical facts relevant to possible treatment of this minor, they are stated on the back of this document. The medical facts are intended to help the doctor, medical personnel, or other person in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by the persons named herein.

I am giving this consent and authorization because my child may need medical care or hospitalization while traveling to or from Spain, or as a result of injuries or illness sustained while in Spain when I am not present to give consent or authorization directly. This consent and authorization is valid from the day my child leaves for Spain until he/she returns home from Spain unless revoked or extended in writing.

The names, addresses and phone numbers of the persons I am so authorizing are as follows:

Jill Flaningam
2916 21st Avenue
Oakland, CA 94602 (510) 534.2495

Jackson Jordan
410 Fairmount Ave. #104
Oakland, CA 94611 (510) 459.4585

Brendan McCarthy
312 34th Street
Manhattan Beach, CA 90266 (415) 850.4881

Christopher Randle
254 Parkview Terrace
Oakland, CA 94610 (510) 251.2515

It is intended that this authorization relieve the physician, dentist, or other person rendering such care or the hospital or institution in which such care is given from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that the persons appointed herein shall be able to act in my stead in making such decisions.

Signature of Parent or Guardian: ____________________________________
Date:____________________
Printed Name of Parent or guardian:
____
Address:____
Medical Insurance Carrier/ Policy Number:
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