

# MINOR AUTHORIZATION FORM

(A nous retourner signé)

Student Name	
GROUP NAME (IF APPLICABLE)	FRENCH JEW'RNEY

I AGREE TO MAKE SURE MY CHILD UNDERSTANDS THAT HE OR SHE MUST:

- BEHAVE REASONABLY AND MATURELY DURING THE PROGRAM.
- OBEY HIS OR HER SCHOOL DIRECTOR, GROUP LEADER, CHAPERONE, HOST FAMILY PARENTS, INSTRUCTORS AND/OR OTHER PROGRAM SUPERVISORS AT ALL TIMES.
- OBEY ALL UNITED STATES LAWS INCLUDING THE MINIMUM DRINKING AGE OF 21 IN THE U.S.

I UNDERSTAND THAT FAILURE TO ABIDE BY THE REGULATIONS ABOVE COULD RESULT IN IMMEDIATE EXPULSION OF MY CHILD FROM THE PROGRAM. BY SIGNING THE FORM BELOW, I AGREE TO THE FOLLOWING:

- THE GROUP LEADER OR SCHOOL DIRECTOR CAN MAKE EMERGENCY DECISIONS FOR MY CHILD WHILE HE OR SHE IS IN THE ASPECT PROGRAM IN THE UNITED STATES.
- I AGREE TO RELEASE THE GROUP LEADER, HOST SCHOOL, ASPECT OR ANY OF THEIR PARENT COMPANIES, SUBSIDIARIES, AFFILIATES, AGENTS, OR EMPLOYEES, FROM ANY LIABILITY RESULTING FROM ANY CAUSES OF ACTION FOR PERSONAL INJURY, DISABILITY, MEDICAL EXPENSES, PROPERTY DAMAGE OF THEFT, OR ANY OTHER CLAIMS THAT MAY ARISE FROM MY CHILD'S PARTICIPATION.
- IN THE EVENT OF A MEDICAL EMERGENCY DURING STUDENT'S PROGRAM, I AUTHORIZE A LICENSED HOSPITAL, PHYSICIAN OR MEDICAL PERSONNEL TO INITIATE TREATMENT FOR MY CHILD.  
*I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR DIAGNOSTIC AND INSURANCE PURPOSES AND FOR FOLLOW-UP TREATMENT IN MY HOME COUNTRY.*  
*I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND THAT I AM THE RESPONSIBLE PARTY FOR ALL EXPENSES INCURRED, AND ON BEHALF OF MY CHILD I ACCEPT THE RISKS ASSOCIATED WITH SAID MEDICAL CARE.*

I, THE PARENT OR GUARDIAN, HAVE READ THIS DOCUMENT AND UNDERSTAND AND AGREE TO ITS CONTENTS:

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*Print Name of Parent or Guardian*

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*Signature of Parent or Guardian*

*Date*