

People to People Sheboygan Chapter

Student Dental Health Certificate

Please keep a copy of the entire application for your records

Student Name

RELEASE

Our son/daughter has our permission to apply to and take part in the People to People Sheboygan Chapter program. We authorize the dentist to release the information requested and to discuss our son's/daughter's health with representatives of People to People Sheboygan Chapter. We affirm that all of the medical information released to People to People Sheboygan Chapter is complete and truthful to the best of our knowledge. As the applicant's parents or guardians, we agree to authorize the People to People Sheboygan Chapter program or the host family to act for us in any emergency, accident or illness in the event our son/daughter enters the People to People Sheboygan Chapter program. If our son/daughter has a recurrence of any previous illness, condition or anything contracted before leaving home, we, the undersigned, authorize the People to People Sheboygan Chapter program to release our son/daughter to our personal care. We will not hold People to People Sheboygan Chapter responsible for any debts incurred by this or any other illness or condition, and we agree to pay for the return travel of our son/daughter.

Parent's or Guardian's Signature

Date

Student's Signature

Date

CERTIFICATE OF DENTAL HEALTH

I have examined the teeth of this student and certify that they are in satisfactory condition.

Dentist's Signature

Date

Dentist's Name Printed

Telephone number

Dentist's Address

City

State

Zip Code