PERMISSION/MEDICAL RELEASE FORM
Please print in ink.

VALID THROUGH AUGUST 31ST, 2016

Student Name:_____

Birthdate:_____**Grade:**_____

Address:_____**City:**_____**Zip**_____

Authorization and Consent for Treatment of a Minor:

(I)(we), the undersigned, parent(s) of _____, a minor, do hereby authorize Pasco Christian Church's leaders as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of, any physician or surgeon licensed under the provision of the *Medical Practice Act,* whether such diagnosis or treatment is rendered at the office of said physician or at a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis treatment or hospital care which the aforementioned physician may, exercise in his best judgment, deem necessary or advisable.

Release of Pasco Christian Church:

_____(parent's name) shall indemnify, hold free and harmless, assume liability for, and defend Pasco Christian Church, its agents, servants, employees, officers, and directors from any other sums which Pasco Christian Church, assertion of liability, or any claim or action founded thereon, arising or alleged to have arisen out of _____(child's name) use of real or personal property belonging to Pasco Christian Church, its agents, servants, employees, officers, and directors, or action or omission by _____(child's name).

Permission to Transport and Participate:

I, _____ (parent's name) hereby grant permission

for, _____ (student's name) to participate with Pasco

Christian Church Youth Ministry. I also give permission for my student to be transported to and

from Pasco Christian Church by a licensed and responsible driver.

_____
Parent Signature   Date

EMERGENCY CONTACT/MEDICAL INFORMATION

Legal Guardian: _____

Day Phone: (____)_____

Evening Phone: (____)_____

Mobile Phone (_____)_____

Parents/Guardian Email Address:_____

Other Emergency Contact:_____

Phone: (____)_____

Physician:_____

Phone: (____)_____

Insurance Co: _____

If none, please check here_____

Policy #, or Group #:_____

Known Medical Conditions:_____

Medication?_____

Allergies?_____

Last Tetanus Immunization? _____

Contact Lenses? Yes_____ No____

Other Information:_____

_____

_____

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