

Medical Release Form

New Hope Community Church • 925 Hale Place #A-10, Chula Vista 91914 • 619-482-7087

Authorization to Consent to Treatment of a Minor

I, (we), the undersigned, parent(s) or guardian(s) of _____, a minor, do hereby certify that _____ is in good health and can travel and participate in the following New Hope sponsored activity(ies): _____.

In consideration of my/our child/ward participating in New Hope Community Church activities, I(we) do hereby authorize the adult youth counselors, coordinators or adult leaders of New Hope Community Church as agent(s) for the undersigned to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment, and hospital care on the advice of any licensed physician or surgeon licensed to practice medicine in the state of treatment, when the need for such treatment is immediate and when efforts to contact me/us are unsuccessful. This authorization is granted pursuant to Family Code §6910. This consent shall remain in effect until: _____.

I (We) hereby release, forever discharge, indemnify and agrees to hold New Hope Community Church its directors, officers, employees, members and volunteers harmless from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the above stated child that occur during any New Hope Community Church activity(ies). The undersigned further agrees to release, forever discharge, indemnify and agrees to hold New Hope Community Church its directors, officers, employees, members and volunteers harmless, for any liability sustained by said church as the result of the negligent, willful or intentional acts of the above named child, including expenses incurred attendant thereto.

Date: _____ Minor's Date of Birth _____

Address _____ City _____ Zip _____

Home phone _____ Cell phone _____

Work phone _____

Signature of Parent(s)/Guardian(s) _____

Print Name(s) _____

Health Insurance Provider: _____ Policy # _____

Dr's. Name _____ Dr's. phone number _____

1. List minor's foods or medications allergies: _____

2. List any medications your child is taking: _____

3. Give the dates of your latest immunizations: Hepatitis B _____ Polio _____ Tetanus _____

4. List any special medical concerns to be aware of: _____

5. Name of another person(s) to be notified if parent(s)/guardian(s) is/are unavailable:

Name _____ Phone _____

Name _____ Phone _____