

Authorization for Medical Treatment

Additional information

I, _____, am the parent or legal guardian of _____, hereinafter, "my child", who was born on _____, _____. My child is attending and participating in activities of Marin Covenant Church located at 195 N. Redwood Dr, San Rafael, CA for the academic year of __2015-20146__.

I hereby authorize the Pastor / Supervisor and his/her officers, agents, servants, or employees who are 18 years of age or older, who supervise the activities at this church into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize the Pastor / Supervisor and his/her officers, agents, servants, or employees who are 18 years of age or older, who supervise the activities at the church to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the Pastor / Supervisor and his/her officers, agents, servants, or employees who are 18 years of age or older who supervise the activities at this church.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

Dated _____, _____

E-Signature of parent or legal guardian (by typing your name you signify that you agree and all information is correct)

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Additional information

Parent / guardian

Address City State Zip

Home phone

Work phone

Cell Phone

Medical / health insurance company Insurance policy no.

In case of emergency, notify parent or guardian Relationship to minor

Allergies / allergic reaction of my child

Medicine being taken by my child

Other information regarding my child's health that a doctor should know