PARENTAL CONSENT

MEDICAL RELEASE

WESTSIDE CHRISTIAN CHURCH

WESTSIDE STUDENT MINISTRY

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone # _____/_____

Person To Notify _____ **#** _____

The undersigned parent or guardian of _____, a minor, do hereby consent to any emergency X-ray, anesthetic medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general special supervision of any physician and surgeon licensed under the provision of the Medical Practice Act.

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 in the exercise of his best judgment may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising this action. I understand and do hereby give my consent to the above stated conditions.

Parent/Guardian Signature _____ **Date:** January 1, 2012 ~ December 31, 2012

PERSONAL INFORMATION:

Student's Birthdate _____/_____/_____ Grade _____ Sex: [ ] F [ ] M

Known Allergies _____

Special Medication _____

Preferred Hospital _____

Physician _____

Dentist _____

Orthodontist _____

Insurance Policy Name _____

Insurance Policy Number _____

Other Relevant Information _____

_____

_____

Emergency Phone Numbers:
Father @ Work _____/_____ Mother @ Work _____/_____
Friend/Relative _____ Phone # _____/_____