CHRIST CHURCH PORTOLA VALLEY

Release Form

Date: September 1, 20__ *Note: Form is valid for one program year, starting on date noted.*

Participant Information

Participant's name: ________________________________ email: _________________________________

Grade: ____

Address: ____ City/State: _________________ Zip: _______

Parent(s)/Guardian(s):

Name(s): ____ / _______________________________________

Telephone numbers:

Day: ____ Cell: ____________________________________

Night: ____ / ____

In case of an emergency, if the above persons cannot be reached, please notify:

Name: ____ Relationship: ____________________________

City of Residence: _________________________________

Telephone (Day): __________________________________(Night): _________________________________

Medical Authorization: I/we, the parent(s) or legal guardian(s) of ______________________________, a minor, hereby authorize and 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 special supervision of any licensed medical personnel on staff of any licensed hospital. This authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority and power to render care which is deemed advisable in the best judgment of the physician.

Date: _______________ Signature: ____________________________________Relationship: _______________

Birth date of minor: _______________ Last tetanus shot: _______________

Allergies: ____

Medications: ____

Special Needs: ____

Family physician: __________________________________Phone: _________________________________

Insurance Co.: _____________________________________Policy/Member #: _______________________

Date: _______________ Signature: ____________________________________Relationship: _______________