SAN GABRIEL
Union Church and Christian School

Medical Authorization Release Form
2010

Student's Name:		Parent/Guardian Name(s):	Grade:
Home Phone:	Cell Phone:	Address:	
Emergency Phone Number:		City:	
Church you usually attend:		Zip:	
Parent's e-mail address			

Date _____ I, (We,) the undersigned, parents of _____ a minor, age _____, do hereby authorize San Gabriel Union Church and its representatives 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 it to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the medical practice act on the medical staff of any accredited hospital, when such diagnosis or treatment is rendered at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care 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 or her best judgment may deem advisable.

The authorization shall remain effective for one year of signing, unless sooner revoked in writing, delivered to said agent(s).

Known Allergies _____ Date of last Tetanus _____

_____ List any medical limitations _____

_____ _____

_____ _____

Medical Insurance Company: _____ Phone: _____

Groups # _____ Member ID # _____

Signed _____ **Dated** _____

(Parent/Guardian signature required to attend)