2014
PARENT PERMISSION - RELEASE FORM
VALLEY CHRISTIAN CHURCH - TULARE, CA.

STUDENT'S FULL NAME_____ BIRTHDATE_____ GRADE____

ADDRESS_____CITY_____ZIP_____

AUTHORIZATION OF CONSENT TO TREATMENT OF MINORS

I authorize VALLEY CHRISTIAN CHURCH, through its agents/and or employees, to 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 physician and surgeon duly licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at said office of said physician or said hospital, and/or any dentist duty licensed under the provisions of the Dental Practice Act whether such diagnosis or treatment is rendered at the office of said dentist or at said hospital.

I authorize VALLEY CHRISTIAN CHURCH, through its agents and/or employees to 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 physician and surgeon duly licensed under the provisions in effect in the foreign state province, country or other state in the United States where the care is rendered, on the medical staff of a hospital, whether such diagnosis or treatment is rendered at said office of said physician or at said hospital, and/or any dentist duly licensed under the provisions in effect in the foreign state/province, country or other state in the United States where the care is rendered whether such diagnosis or treatment is rendered at the office of said dentist or at said hospital

I understand 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 the aforesaid agents and/or employees to give specific consent to any and all such diagnosis, treatment or hospital care which the physicians and/or dentists, in the exercise of their best judgment, may deem advisable and necessary.

I understand that the licensing procedure in foreign countries and medical and/or dental care in foreign countries may not be the same standards and quality as found within the United States.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California, with the understanding that foreign doctors and doctors in other states within the United States are not licensed under the Medical Practice Act and that foreign dentists and dentists in other states within the United States are not licensed under the Dental Practice Act. This authorization shall remain effective until **January 10, 2014**, unless revoked sooner in writing delivered to said agent and/or employees or VALLEY CHRISTIAN CHURCH. A photostatic copy or carbon copy of this document will have the same force and effect as an original. My child is covered under the following:

Health insurance plan(s)_____ Address of insurance co._____

Plan-Group # is:_____ My child is covered under Medi-cal ❑ YES ❑ NO Medi-cal # is:_____

My child's health care coverage as indicated above is valid and will remain in effect while my child is traveling in a foreign country(ries) and/or states within the United States ❑ YES ❑ NO

I understand that should it become necessary for the medical and/or dental care to be provided; the authorizing agent and/or employee of VALLEY CHRISTIAN CHURCH and VALLEY CHRISTIAN CHURCH assume no responsibility for payment of any and all expenses which may be incurred. I understand that I am fully responsible for payment of all medical and/or dental costs and/or fees which may be incurred. I agree to hold harmless the authorizing agent and/or employee of VALLEY CHRISTIAN CHURCH and VALLEY CHRISTIAN CHURCH from any liability for payment for said care, should it be authorized.

Mother_____Home Phone_____ Cell Phone_____
Signature
Work Phone _____

Father_____Home Phone_____Cell Phone_____
Signature
Work Phone_____

Legal Guardian_____
Signature address phone

Other Emergency Contact _____
name address phone

Family Doctor_____
name address phone

Medication(s)_____Allergies_____

Diabetic: ❑ YES ❑ NO Bleeder: ❑ YES ❑ NO Dietary Needs_____Last Tetanus Shot (date)_____rev 07/14