

• **AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR**

(I) (We), the undersigned parents of \_\_\_\_\_, a minor, do hereby authorize Advent Lutheran Church and/or adults designated as agents for Advent Lutheran Church, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care or service; which is deemed advisable and is to be rendered to said minor, under the general or specific supervision of any physician and surgeon licensed under the supervision of the Medicine Practice Act of the State of California or any state within the United States of America, or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. This authorization is given as specific consent to any and all such diagnosis, treatment, or hospital care; which the aforementioned physician, in the exercise of his best judgement, may deem advisable to protect the life and health of said minor child.

In consideration of the benefits to be derived from the aforesaid outings, (I) (We) hereby voluntarily waive any claim against Advent Lutheran Church and the owner and driver of the vehicle, in which my (our) child (ward) is to receive transportation to said activities.

**Dated** \_\_\_\_\_  
**Father** (print) \_\_\_\_\_ and/or  
**Mother** (print) \_\_\_\_\_ or  
**Legal Guardian** \_\_\_\_\_  
**Witness** \_\_\_\_\_ **Dated** \_\_\_\_\_

**EMERGENCY INFORMATION & AUTHORIZATION for TREATMENT of a MINOR**

To be completed by the parents or guardians

**Minor's Name** \_\_\_\_\_ **Birth Date** \_\_\_/\_\_\_/\_\_\_ (MO/DAY/YR)

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** (\_\_\_\_) \_\_\_\_\_ **Parent Business Phone** (\_\_\_\_) \_\_\_\_\_

**Neighbor/Relative's Name** \_\_\_\_\_ **Telephone** (\_\_\_\_) \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **Address** \_\_\_\_\_

**City** \_\_\_\_\_ **Telephone** (\_\_\_\_) \_\_\_\_\_

**Date of Last Tetanus Shot** \_\_\_\_\_

**Specific Medical Problems /Allergies** \_\_\_\_\_

**List Regular Medications given to said minor and the Name of Physician prescribing said Medication(s)** \_\_\_\_\_

**Name & Policy Number of Insurance** \_\_\_\_\_

**Signatures of Parent(s) or Guardians** \_\_\_\_\_

**\*Dated** \_\_\_\_\_

*\*THIS FORM IS VALID FOR ONE YEAR FROM THE DATE LISTED.*