

JERICO ROAD CHRISTIAN FELLOWSHIP ("JRCF") - MEDICAL RELEASE FORM

This release form gives consent for my son/daughter to participate in activities at JRCF.

Child's Name _____ Age _____ Date of Birth _____ Grade _____
Address _____ Apt/Rm# _____ City _____ Zip _____
Parent's / Guardian's Name(s) _____ Relationship _____
Home Phone _____ Cell Phone(s) _____ Work Phone _____
Employer _____ of which Parent / Guardian _____
Employer's Address _____ Phone _____
Doctor _____ Phone _____ Preferred Hospital _____
Medical Insurance _____ Policy # _____
Allergies/Special Needs _____

IN CASE OF EMERGENCY, WHEN PARENT / GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

Name _____ Relation _____ Phone _____ Pgr/Cell # Phone _____
Name _____ Relation _____ Phone _____ Pgr/Cell # Phone _____

I/We the Parents/Guardian of the minor named above do hereby authorize JRCF, as agents 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 is rendered under, the general or specific supervision of any physician or surgeon 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 the office of said physician or hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given in advance to provide authority and power of the part of the aforesaid agents to give a specific consent to any and all such diagnosis, treatment or hospital care which the aforesaid physician in the exercise of his best judgment deems advisable. The authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of CA.

Mother/Father or Legal Guardian Signature Printed Name _____ / ____ / ____
Today's Date