

# PENINSULA COMMUNITY CHURCH

## Medical Release Form

(One form per child)

Please Print Clearly

Name of Child \_\_\_\_\_  
Last First

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

(I)(We), the undersigned, parent(s) of the above-named child, a minor, do hereby authorize the Ministry Leaders of Peninsula Community Church of Rancho Palos Verdes 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 is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood 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 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 best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective through October 1, 2011, unless sooner revoked in writing delivered to said agent(s).

The insurance of Peninsula Community Church is co-insurance. Your family's individual insurance will be used first before the insurance of Peninsula Community Church.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Name Print \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Cell Phone \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy/ID Number \_\_\_\_\_

Allergies or Medical Conditions \_\_\_\_\_

Symptoms, Treatment \_\_\_\_\_

**\*EMERGENCY CONTACT PERSON MUST BE SOMEONE OTHER THAN THE PARENT(S) OR GUARDIAN\***

Emergency Contact Name \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Cell Phone \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

**PLEASE NOTIFY THE CHURCH OFFICE IMMEDIATELY OF ANY CHANGES IN ANY OF THE ABOVE INFORMATION.**  
**pccmoses/children/medicalforms**