NAME OF CHURCH
SEVENTH-DAY ADVENTIST CHURCH
Church's Street Address, City, State Zip
Phone and Fax Numbers

AUTHORIZATION FOR MEDICAL TREATMENT FOR MINORS

I, _____ (printed name of parent or guardian) am the parent or legal guardian of _____ (printed name of minor), referred to as "my child."

My child is attending and participating in activities at _____ Seventh-day Adventist Church, a part of the Southern California Conference of Seventh-day Adventists, located at _____

I authorize the Pastor and his/her officers, agents, servants, or employees who are 18 years of age of older, who supervise the activities at this organization into whose care my child has been entrusted, to consent to medical or dental care, or both, for my child under Sections 6901, 6902, and 6910 of the California Family Code.

The authority granted by this authorization includes the authority to consent to any radiological (x-ray) examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon, licensed California laws or equivalent statutes of other States, for my child.

I further authorize the Pastor and his/her officers, agents, servants, or employees who supervise the activities of the organization to receive physical custody of my child, under Section 1283(a) of the California Health and Safety Code, upon completion of any treatment, and I specifically instruct any treating health facility to surrender custody of my child to the Pastor and his/her officers, agents, servants, or employees who are 18 years of age or older who supervise the activities at this organization.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the Principal and his authorized designee, to exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist and surgeon. A photocopy of this authorization shall be as valid as the original. This Authorization shall remain valid until revoked in writing.

The attached information sheet contains the complete and accurate health and emergency information to assist in providing assistance to my child.

_____	_____	_____
Signature of parent or guardian	Date signed	City and State where signed

NAME OF CHURCH
SEVENTH-DAY ADVENTIST CHURCH

SUPPLEMENT TO AUTHORIZATION FOR
MEDICAL TREATMENT FOR MINORS

CONFIDENTIAL HEALTH AND EMERGENCY INFORMATION

My child's information:

Full Legal Name: _____ _____ _____
First Middle Last

Address: _____
Number and street

_____ _____ _____
City State Zip code

Home phone: _____ _____
Area code Phone number

Birth date: _____

Health Insurance: Health Insurance Company: _____

Name of insured: _____

ID Number: _____

Medications being taken or allergies: _____

_____ ___

PLEASE ATTACH A PHOTOCOPY OF THE HEALTH INSURANCE CARD.

Parent/Guardian information:

Printed Name: _____

Address (if different): _____

_____

Phone numbers: Home: _____

Work: _____

Cell or pager: _____

Parent's E-mail: _____