

Please print clearly.



## ANNUAL PARENT/GUARDIAN RELEASE AND MEDICAL AUTHORIZATION FORM

1000 N. Studebaker Road, Long Beach, CA 90815

Phone: 562.296.6490 Website: www.cclb.org

Current Grade Level \_\_\_\_\_

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(last) (first)

Address: \_\_\_\_\_  
(street) (city) (zip code)

Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Phone numbers: Home: \_\_\_\_/\_\_\_\_ Mother's work/cell: \_\_\_\_/\_\_\_\_ Father's work/cell: \_\_\_\_/\_\_\_\_

Parents Email Address: \_\_\_\_\_

### Authorization to consent to medical treatment of minor:

I/We the undersigned parent(s)/guardian(s) of \_\_\_\_\_ (child's name), a minor, do hereby authorize Cornerstone Church Children/Youth Ministry leaders 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 specific supervision of any physician and/or surgeon licensed under the provision of the Medical Practice Act, or a dentist licensed under the provisions of the Dental 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 or dentist, in the exercise of his/her best judgment, may deem advisable. It is further understood that efforts shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached. I will not hold liable Cornerstone Church, its leaders, employees, or representatives, for medical aid rendered and will reimburse Cornerstone Church for any medical or other expenses incurred in the care of my child.

This authorization is given pursuant to Section 6910 of the California Family Code. This authorization shall remain effective through the above-named minor's graduation from high school, unless sooner revoked in writing delivered to said agent(s).

### Release of Cornerstone Church:

We/I, \_\_\_\_\_ (parent's name(s)), hereby voluntarily release, discharge, indemnify, hold free and harmless, assume liability for and promise to defend Cornerstone Church, its agents, servants, employees, officers and directors from any and all liabilities, claims, demands, causes of action, and costs and expenses (including but not limited to attorney's fees, reasonable investigative and discovery costs, court costs and all other sums which Cornerstone Church may be forced to incur) arising or alleged to have arisen out of \_\_\_\_\_ (child's name) use of real property or personal property belonging to Cornerstone Church, its agents, servants, employees, officers and directors, or by action or omission by (child's name). This release is intended to be as broad and inclusive as is permitted by California law and shall be construed and interpreted in accordance with California law.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ If none, please check: (\_\_\_\_)

Insurance policy # \_\_\_\_\_ Group # \_\_\_\_\_

Known medical conditions: \_\_\_\_\_

Medication(s): \_\_\_\_\_

Allergies: \_\_\_\_\_

Last tetanus immunization: \_\_\_\_\_ Contact lenses: \_\_\_\_\_

Will you allow blood transfusions? \_\_\_\_ Yes \_\_\_\_ No

Date form completed: \_\_\_\_\_ First time form completed? \_\_\_\_ Yes \_\_\_\_ No