Calvary Community Church

EMERGENCY MEDICAL AUTHORIZATION 2010

Child's Name _____ Birthday _____
Last First Month / Day / Year

Address _____ Home Phone _____
Street City Zip

Parent's Names _____ Work Phone _____

Doctor's Name _____ Phone _____

Health Insurance Co. _____ Phone _____

Health Insurance Numbers _____

Medical Release Authorization:

If a medical emergency should arise while my child, named above, is at Calvary Community Church and **I cannot be contacted, I give permission** to Calvary Community Church's Children's Minister, Children's Ministry Directors, or ministry staff personnel to **select a physician** and/or a **hospital** for my child's care. I also give the hospital and/or physician selected by Calvary Community Church my permission to **hospitalize**, **treat**, or **order injections**, **anesthesia**, or **surgery** necessary to save my child's life.

Parent's Signature _____ Date _____

NOTARY'S SIGNATURE _____ Date _____

(Please fill out medical history on back side of card.)

MEDICAL INFORMATION

Does this child have any condition that would restrict their activity while in our care or require special attention?

NO [ ] YES [ ] If yes, please explain:

_____

_____

_____

_____

Does this child have any allergies (food, medicine, bees, etc) ?

NO [ ] YES [ ] If yes, please describe:

_____

_____

_____

_____