

**Permission and Medical Release Form**  
Vacation Bible School July 21-25, 2008  
Yorba Linda Presbyterian Church

I (We) the undersigned parent, parents, or legal guardian of \_\_\_\_\_, a minor, do hereby give consent for a responsible representative of Yorba Linda Presbyterian Church to procure medical and/or dental treatment as deemed necessary for the above referenced minor. And should the need arise, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the Medicine Provisions Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. 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 to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but any of the above treatments will not be withheld if the undersigned cannot be reached. I will not hold liable the Yorba Linda Presbyterian Church, its officers, or leaders for medical aid rendered and will reimburse the Yorba Linda Presbyterian Church for medical or other expenses incurred in the care of my minor child.

This authorization is given pursuant to section 25.8 of the Civil Code of California and remains effective only for the dates listed above.

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Physician or Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Is minor currently on medication? No \_\_\_\_ Yes \_\_\_\_ If yes, please specify all medications and dosages:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Allergies: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** If minor has a chronic medical condition requiring special care, please attach information regarding said condition and instructions for appropriate treatment along with any necessary emergency supplies.