

HILLSIDE CHURCH
545 Hillside Avenue, San Jose, CA 95136
(408) 269-4782

CHILD'S NAME _____ AGE _____ DOB _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

EMERGENCY PHONE NUMBER: _____

MEDICAL TREATMENT AUTHORIZATION

(I, (We), parent(s), (guardians) of _____ do hereby authorize the Hillside Evangelical Free Church as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office of said physician or at said 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 the aforesaid agents 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 until September 30, 2012.

SIGNED _____ DATE _____

SPECIFIC INFORMATION OR INSTRUCTIONS TO PHYSICIAN OR NURSE:
(Include known medical problems, etc.)

KNOWN ALLERGIES:

INSURANCE INFORMATION (Company and Policy Number)

Please do not photocopy this document. (Exception: parent making a personal copy.)