

**ST. CROSS BY-THE-SEA EPISCOPAL CHURCH
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

As legal custodian of _____, a minor, I hereby authorize _____ or his or her designee into whose care the aforementioned minor has been entrusted, to consent to an x-ray, examination, anesthetic, medical or surgical diagnoses, treatment (such as operations, drugs, emergency care and/or hospitalization) are to be rendered to said minor upon the advice of any licensed physician and/or dentist. I understand that this authorization is given in advance of any required diagnosis, treatment or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which a licensed physician or dentist may deem necessary. This authorization shall also include the right of the aforementioned agent(s) to commit any of our insurance or other funds that may be required to carry out or secure such medical treatment.

This authorization shall remain effective for the full calendar year unless revoked in writing and delivered to said agent(s). I understand that St. Cross Episcopal Church, its employees, volunteers or agent(s) and its Vestry assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedics, transportation, hospitalization, and any examination, x-ray, or treatment provided in relation to this authorization shall be my responsibility, whether covered by insurance or not.

FAMILY DOCTOR	ADDRESS	DAYTIME PHONE
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FAMILY DENTIST	ADDRESS	DAYTIME PHONE
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HEALTH INSURANCE CARRIER	POLICY NUMBER	PHONE
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MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:

CURRENT PHYSICAL LIMITATIONS OR MEDICATIONS USED:

In case of an emergency, should St. Cross Episcopal Church give first aid? _____

Should a doctor be contacted? _____ Can the Church dispense Aspirin or Tylenol? _____

Please list illness or serious accidents during the last year: _____

Underline or circle any of the following conditions which affect your child: epilepsy, fainting spells, asthma, diabetes, allergic reactions to bee stings, heart condition, hearing problem, vision problem. Other:

I have not been advised by a physician that the above-referenced minor should not participate in group activities of the nature sponsored by St. Cross Episcopal Church.

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME OF PARENT/GUARDIAN: _____

DATE: _____

