

Medical/Image Release form

Participant information

Event name: _____ Event date: _____

Participant's name: _____ E-mail: _____

Grade: _____ Church: _____

Address: _____ City/State: _____ Zip: _____

Parent(s)/guardian(s) —

NAME(s):

_____ / _____

TELEPHONE NUMBER(s):

day: _____ / day: _____

night: _____ / night: _____

In case of an emergency, where the above persons cannot be reached, please notify:

Name: _____ Relationship: _____

City of residence: _____

Telephone (day): _____ (eve): _____

Medical authorization

I/we, the parent(s) or legal guardian(s) of _____, a minor, hereby authorize and 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 special supervision of any licensed medical personnel on staff of any licensed hospital. This authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority and power to render care, which is deemed advisable in the best judgement of the physician.

DATE:

SIGNATURE:

RELATIONSHIP:

Birthdate of minor: _____ Last tetanus shot: _____ Social security number: _____

Allergies: _____

Medications: _____

Special needs: _____

Family physician: _____ / Phone: _____

Insurance Co.: _____ / Policy #: _____

Photo and audio release

I give the Episcopal Diocese of California permission to take photographs, videotape and/or record the voice of _____, a minor and to use those images and recordings in diocesan publications only.

DATE:

SIGNATURE:

RELATIONSHIP:

Adapted from the Participant Form, diocesan Department of Youth and Young Adult Ministries