

**Holy Cross Lutheran Church
Medical, Liability & Photo Release**

15885 Los Gatos Almaden Rd, Los Gatos, CA 95032
408-356-3525 – www.holycrosslosgatos.com

This authorization will be kept on file & is effective for one year after signing. It must be reviewed, updated & signed each year to reflect any changes & remain current.

****Please attach a copy of Medical Insurance Card.****

Permission to participate & authorization for medical treatment (Domestic and foreign):

1. (Check one) ___ Myself ___ I am the parent/legal guardian of the following minor child:

Name _____ Birth date _____ Age _____

Address _____

City _____ State _____ Zip _____

If minor child, please list Parents'/Guardians' Names:

2. In the event of an emergency, please contact (please provide 2):

Name, relationship, day & evening phone:

1. _____

2. _____

3. I authorize Holy Cross Lutheran Church, through its agents and/or employees, to 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 physician and surgeon duly licensed under the licensed hospital, provision in effect in the foreign state/province, country or other state in the US where the care is rendered, whether such diagnosis or treatment is rendered at said office of said physician or at said hospital, and/or any dentist duly licensed under the provisions, in effect in the foreign state/province, country or other state in the US of the dental practice act, whether such diagnosis or treatment is rendered at the office of said dentist or at said hospital.
4. I understand 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 and/or employees to give specific consent to any and all such diagnosis, treatment or hospital care which the physician and/or dentist, in the exercise of their best judgment, may deem advisable and necessary.
5. I understand that the licensing procedure in foreign countries and medical and/or dental care in foreign countries may not be of the same standards and quality as found within the US.
6. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California, with the understanding that foreign doctors and doctors in other states within the US are not licensed under the medical practice act, and that foreign dentists and dentists in other states within the US are not licensed under the Dental Practice Act. This authorization shall remain effective until one year from the date signed unless revoked sooner in writing, delivered to said agent and/or employee of Holy Cross Lutheran Church. A photocopy of this document will have the same force and effect as an original.

7. (Check one) I am... My child is... covered under the following health insurance plan(s):

Policy or Group Number _____ Company phone # _____

Policy or Group Number _____ Company phone # _____

OR

(Check one) I am... My child is... covered under Medi-Cal _____ Number _____

8. (Check one) My... My child's... health care coverage as indicated above is valid and will remain in effect while (Check one) I am... My child is... traveling with Holy Cross Lutheran Church: _____ Yes _____ No

9. I understand that should it become necessary for the medical and/or dental care to be provided, the authorizing agent and/or employee of Holy Cross Lutheran Church assume no responsibility for payment of any and all expenses which may be incurred. I understand that I am fully responsible for payment of all medical and/or dental cost and/or fees which may be incurred. I agree to hold harmless the authorizing agent and/or employee of Holy Cross Lutheran Church from any liability for payment for said care, should it be authorized.

10. Special information or instruction:

Family doctor _____ City _____

Phone _____

Dentist _____ City _____

Phone _____

Medications currently taking _____

Allergies & other health info (Please explain any checked yes)

Insect stings Heart conditions Frequent colds Drugs

Other allergies Chronic Asthma Frequent stomach upsets Hay fever

Diabetes Epilepsy or other nervous disorder Physical handicap

Problems with bleeding Sleep walking

Date of last tetanus shot _____

Dietary needs _____

Any activity restrictions No Yes: What restrictions _____

Other _____

11. I give permission for (Check one) My My child's... picture to be used in any church related publicity, which may include internet and/or print materials. _____ Yes _____ No

I acknowledge that I have read the above information and understand its contents.

Signature _____ Date _____

(Check one) Myself Parent and/or legal guardian (Signature)

Phone _____ Alternate phone _____

For updates in future years: I have reviewed the above information & made necessary changes to reflect current personal info (if many changes, please complete new form).

1. Sign & date _____

2. Sign & date _____

3. Sign & date _____

4. Sign & date _____

5. Sign & date _____

6. Sign & date _____