



## EMERGENCY MEDICAL RELEASE

Please fill in completely and return to:

MISSION HILLS CHURCH  
24162 Alicia Parkway, Mission Viejo, CA 92691  
(949)586-4510  
www.missionhillschurch.com

Please be advised that the bearer of this form has full and complete authority to approve any emergency medical or dental care deemed necessary for my son(s) or daughter(s), \_\_\_\_\_

Minor's name(s)

This authorization includes x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care. Such diagnosis or treatment is to be rendered under the general supervision of any dentist, physician, or surgeon licensed under the provisions of the Medical Practice Act, whether at the office of said dentist or physician or at a hospital.

I do further authorize said agent to select transportation to chosen dentist, physician, or hospital.

This authorization will remain in effect while said minor is en route to or from involved or participating in any program or activity authorized by MISSION HILLS CHURCH, unless revoked by the undersigned in writing and delivered to the aforesaid agent.

I hereby authorize any hospital which has provided treatment to the above named minor(s) to surrender physical custody of such person to said agent upon completion of treatment.

This authorization is given pursuant to the provisions of Section 25 of the Civil Code of California, and to Section 1283 of the Health and Safety Code of California.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Insurance, Policy Holder and Policy \_\_\_\_\_  
Parent's Name & Cell Phone \_\_\_\_\_ Date of Last Tetanus \_\_\_\_\_