

# MEDICAL AUTHORIZATION SLIP

TO WHOM IT MAY CONCERN,

Date: \_\_\_\_\_

AS THE PARENT/GUARDIAN OF: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Grade: \_\_\_\_\_

I authorize treatment for sickness or injury of any nature by a licensed medical doctor as that doctor may deem advisable during any event sponsored by the First Presbyterian Church, 830 Padre Drive, Salinas, California 93901. I further request and authorize the use of any hospital facilities, which may become necessary in connection with such care and treatment. I understand that I am financially responsible for any medical treatment my child receives.

In consideration of the foregoing, I do hereby release from all liability all persons connected with providing such care and treatment and I agree to reimburse such persons for the cost of such care and treatment.

Please list any allergies or other medical information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Family Physician: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

In the event I become disabled while my child is participating in this event or unable to receive my child upon return from this event, I do hereby direct and authorize the leaders of the event to make all necessary arrangements to return my child to the care and control of an immediate family member or designated representative as listed below as soon as practical:

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PARENT/GUARDIAN:

Print Name: \_\_\_\_\_ Student Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Print Name: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_