

Medical Authorization and Release

Name: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Phone Number: Home: _____ Work: _____ Cell: _____

Physician Information:

Name: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Emergency Contact:

Name: _____

Address: _____ City, State, Zip: _____

Phone Number: Day: _____ Night: _____

Medical Conditions:

Last date of tetanus or booster shot: _____

List medical conditions for which you are currently being treated: _____

List allergies: _____

We, the parents/guardians of _____, hereby give our permission for treatment by a licensed physician if medical treatment is deemed necessary by the physician. In case of surgical emergency, we also give our consent to medical procedures diagnosed and prescribed by the attending licensed physician.

By affixing my signature below, I do hereby agree to hold harmless and indemnify SC Woman's Missionary Union (SC WMU) and all agents and representatives thereof (the "Releasees") from all claims of losses, injuries, damages, and/or death that may result in me or my child participating in the missions program of SC WMU. I further agree to waive any rights of legal action against the Releasees.

Custodial Parent's or Guardian's Signature

Date

Major Medical Insurance Company Policy No.: _____

Before me the undersigned authority, a Notary Public in and for said County and State, on the day personally appeared the person whose name is subscribed to the following instrument and declared that the foregoing instrument is true and correct.

Given under my hand and seal of office this _____ day of _____, 2008.

_____, Notary Public in and for _____ (county),

_____ (state).

My commission expires _____.