Lutheran Church of the Incarnation

1701 Russell Blvd, Davis, CA 95616 530-756-5500

EMERGENCY MEDICAL TREATMENT AUTHORIZATION AND RELEASE

Name_____ Birthdate_____ Age_____
Last First Middle (mm/dd/yy)

Home Address_____
Street & Number City State ZIP

Gender: _____Male _____ Female

Parent or Guardian _____ Phone (_____)_____

Home Address _____ Phone (_____)_____
(if different than above) Street & Number City State ZIP

Business Address _____ Phone (_____)_____
Street & Number City State ZIP

Other Parent or Guardian or Emergency Contact _____

Home Address _____ Phone (_____)_____
(if different than above) Street & Number City State ZIP

Business Address _____ Phone (_____)_____
(if different than above) Street & Number City State ZIP

If not available during emergency, notify_____

Home Address _____ Phone (_____)_____
Street & Number City State ZIP

Health Insurance Carrier _____ Policy # _____

Family Physician _____ Phone (_____)_____

Photocopy of the front and back of health insurance card must be attached to this form
Keep a copy of this form for your record.

I authorize the emergency medical treatment of my minor child, _____, by the Lutheran Church of the Incarnation leader who deems the emergency medical treatment necessary, in his or her opinion, during a youth ministry sponsored activity. I also agree to release and hold harmless said leader who, administers and/or authorizes such emergency medical treatment. This Authorization and Release is to be in effect from October 1, 2016 to midnight September 30, 2017.

_____ _____
Parent or Guardian Signature *Date*