Coastal Academy

Medical Release

Name of child____

Birth date______________________ Date of last Tetanus booster______________

Health problems, medical or food allergies______________________________

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I (We) the undersigned parent, parents, or guardians of the minor child(ren) named above, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or specific supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Health Services. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority to render care, which the aforementioned physician in the exercise of his/her best judgement may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. The undersigned also assumes the responsibility for any of the costs connected with such treatment and hereby releases the leaders and members of

____________COASTAL ACADEMY____________ (Name of the group) from any liability therefore.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under any emergency circumstances in my absence.

Signature of Father/Guardian________________________________ Date____________

Signature of Mother/Guardian________________________________ Date____________

Home phone number______________________ Emergency phone number______________________

Address____

City______________________________ State________ Zip__________

Physician's Name______________________________ Phone______________________

Insurance Company and Policy #____

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