

ST. PAUL LUTHERAN CHURCH

701 SOUTH PLEASANT AVE. LODI, CA 95240 (209)368-2747

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT PARENT CONSENT FOR PARTICIPATION IN ALL YOUTH ACTIVITIES

Name _____ Birthdate _____ Gender: M F

Address _____ City _____ Zip _____ Hm. Phone/Cell _____

In an emergency notify _____ Hm. Phone/Cell _____

Family Doctor _____ City _____ Phone _____

PHYSICAL CONDITION _____ (Check and specify if other than good, give details below).

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye, ear, nose, throat |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach upsets |
| <input type="checkbox"/> Nervous System Disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Frequent Colds |

Any swimming restrictions: Yes _____ No _____ (give details below)

Any activity restrictions: Yes _____ No _____ (give details below)

Please list any allergies _____

To my knowledge he/she Has _____ Has not _____ been exposed to contagious, infectious disease in the last 3 weeks.

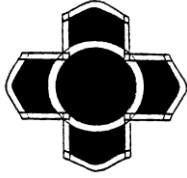
Insurance Company _____ Policy Number _____

(I), (We) the undersigned, parent(s) of _____ MINOR, do hereby authorize the youth director/children's education director for the undersigned to consent to any x-ray, anesthetic, medical or surgical diagnosis of treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medicine Practice Act of the Business and Professional Code of California, Section 2000, on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

CONNECTING WITH GOD, EACH OTHER AND THE WORLD. . .

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I know of no health reason why my son/daughter may not participate in any Youth activities.

SIGNATURE _____ DATE _____

COMMENTS _____

PHOTOGRAPHY AUTHORIZATION: I GIVE THE CHURCH PERMISSION TO PHOTOGRAPH MY CHILD(REN) AND THAT ANY PHOTOGRAPH CONTAINING THEIR IMAGE TO BE USED FOR DISPLAY OR REPRODUCTION AT ST. PAUL LUTHERAN CHURCH OR ON THE ST. PAUL WEBSITE.

SIGNATURE OF PARENT/GUARDIAN _____

ARE YOU INTERESTED IN ANY OF THE FOLLOWING?

- MORE INFORMATION ABOUT ST. PAUL A VISIT FROM THE PASTOR BAPTISM/MEMBERSHIP

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OFFSITE AUTHORIZATION: I UNDERSTAND THAT MY CHILD(REN) MAY WALK WITH ADULT SUPERVISION WITH THEIR STUDENT GROUP TO EITHER THE NEEDHAM SCHOOL FIELD AND PLAYGROUND OR TO THE GROUNDS OF FIRST UNITED CONGREGATIONAL CHURCH, BOTH OF WHICH ARE NOT MORE THAN 1 BLOCK FROM ST. PAUL.

SIGNATURE OF PARENT/GUARDIAN _____

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