EASTMINSTER PRESBYTERIAN CHURCH
106 North Riverside Drive
Indialantic, FL 32903
(321) 723-8371
www.epcfl.org

RELEASE FORM

(I/We), the undersigned parents(s) of _____, minor, do hereby authorize **Eastminster Presbyterian Church** as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician and surgeon, 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 but 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/her best judgment may deem advisable.

I am aware that my child is allergic to the following medication(s): _____
_____.

This authorization shall remain effective until _____, 20 unless sooner revoked in writing and delivered to said agent(s).

Guardian's Names (print): _____

_____

Address (of child): _____

Phone Numbers (cell/home): _____

Date of Birth: _____

Dated: _____

Signed (father): _____

Signed (mother): _____

Signed (legal guardian): _____

INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____

Please provide copy of card (both front and back) and attach with form.

_____ _____
Parent's or Guardian's Signature Date