

**CALVARY CHAPEL OF EL CAJON YOUTH DEPARTMENT**  
**MEDICAL RELEASE FORM**  
Effective as of January 2009

*This release form covers transportation to and from Calvary Chapel of El Cajon and gives consent for my son/daughter to participate in any and all activities and/or events with Calvary Chapel of El Cajon.*

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ Apt. # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ Phone(s) \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Hospital \_\_\_\_\_ General Address \_\_\_\_\_  
Insurance Provider \_\_\_\_\_ Policy or Med. Record # \_\_\_\_\_

**IN CASE OF EMERGENCY, WHEN PARENT / GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:**

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_ Pgr/Cell # Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_ Pgr/Cell # Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_ Pgr/Cell # Phone \_\_\_\_\_

**PLEASE CHECK THE APPROPRIATE BOX**

Does your teen have any physical restrictions? Yes  No  Does your teen have any allergies? Yes  No   
Is your teen presently taking any medication? Yes  No  Does your teen experience asthma? Yes  No   
Is your teen allergic to any medication? Yes  No

If you checked yes to any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_

I/We the Parents/Guardian of the minor named above do hereby authorize Calvary Chapel of El Cajon, as agents 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 rendered under, the general or specific supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given in advance to provide authority and power of the part of the aforesaid agents to give a specific consent to any and all such diagnosis, treatment or hospital care which the aforesaid physician in the exercise of his best judgment deems advisable. The authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of CA.

\_\_\_\_\_/\_\_\_\_\_/2008  
Mother/Father or Legal Guardian Signature Printed Name Today's Date