Student Ministries Emergency Card • 2011 – 2012

South Hills Community Church • 6601 Camden Ave., San Jose, CA 95120-1908 • 408-268-1676

Please Print Clearly!

Student's Name:			
First:	**Middle:**	**Last:**	**Gender:**

Address:		
Street:	**City:**	**Zip Code:**

Home Phone Number:	**Student Cell Phone:**	**Date of Birth:**	**Grade in Fall 2011:**

School:	**Student's Email Address:**

Allergies or Other Concerns:

Parents:			
Father's Name:	**Father's Cell Phone:**	**Father's Work Phone:**	**Father's Email:**
Mother's Name:	**Mother's Cell Phone:**	**Mother's Work Phone:**	**Mother's Email:**

Student Lives With:

❑ Both Parents ❑ Dad ❑ Mom ❑ Other: ________________________________

THERE ARE TWO SIDES TO THIS FORM, PLEASE COMPLETE THE OTHER SIDE…

AUTHORIZATION OF CONSENT FOR TREATMENT OF A MINOR

(I) (We), the undersigned parent(s), guardian(s) of the minor child named on the reverse of this card, do authorize an official of South Hills Community Church to act as designee for the minor named on the reverse to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and/or hospital care which is prescribed by, and is or is to be rendered under the special supervision of any licensed physician or surgeon, whether such diagnosis or treatment is rendered at the office of said physician or surgeon, or at a hospital, clinic, urgent care center, or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or clinic or hospital care being rendered and is given to provide authority and power on the part of the aforesaid designee to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician/surgeon may, for reasons he/she deems appropriate, prescribe.

(I) (We) hereby authorize any hospital or clinic that has provided treatment to the minor named on the reverse to surrender physical custody of such minor to (my) (our) named designee from South Hills Community Church upon completion of treatment. This authorization is given for designee(s) for those times that (I) (we) cannot be reached by telephone at home or work at the numbers listed on the reverse of this form.

This authorization is not to be construed as releasing any physician or surgeon from any requirement that he or she adhere to the lawful standard of care in attending to the named minor and is not to be construed as creating any financial responsibility on the part of South Hills Community Church or the respective directors, officers, employees, and agents as well as named officials thereof for any health care provided for the reverse named minor. PARENTS ARE RESPONSIBLE FOR PAYMENT.

This Authorization to Consent to Treatment of a Minor shall be in full effect for the date range from 1 June 2011 to 31 May 2012.

Parent/Guardian Signature: ______________________________ **Date Signed**: ____________________

In case of emergency when neither parent can be reached, please notify:

Name:	Address:	Phone:	Relationship to Student:
1) ____________	____________	____________	____________
2) ____________	____________	____________	____________

Name of Health/Medical Insurance Company: ____________ **Group #:** ________ **Policy #:** ____________

Name of Doctor: ______________________ **Preferred Hospital:** ______________________

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