MEDICAL RELEASE

I,______________________________ declare that I am the _____________________________ (relationship of legal guardian) of ______________________________ (Youth), and authorize a representative of Hosanna Lutheran Church, in whose care, custody, and control my chid is temporarily entrusted, to obtain and consent to whatever medical treatment is deemed necessary, of any and all kinds, from any physician, surgeon, anesthesiologist, nurse, or x-ray or medical technician, at any medical facility considered appropriate for the health and well-being of my child named above. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I hereby agree to indemnify and hold harmless from any expenses of claims of any nature the adults, of any person or entity which provides or causes to be provided examination, treatment or hospital care pursuant to this authorization except to the extent such adult person, or entity is negligent and agree to make or cause to be made, payment for such examination, treatment or hospital care.

This authorization is effective until my child is 18 years of age. I will provide information in the future should my child's physical condition or medical requirements change.

____ DATE: ____________________

Parent / Legal Guardian

Printed Name: _______________________________ Phone: ____________________

Relationship: ________________________________

MEDICAL INSURANCE INFORMATION

Insurance Company: ___________________________ Phone: _________________________

Member's Name: ______________________________ Policy Number: __________________

HMO __________________ PPO __________________