AUTHORIZATION FOR MEDICAL TREATMENT

I, _____, am the parent or legal guardian of

_____ (hereinafter "my child"), who was born on , _____.

I hereby authorize Arlene Jones, or Becky Hessling, or Ben Forrester, leaders of the Cornerstone Church's Winter Retreat, 2025, into whose care my child has been entrusted, in the event that I cannot be reached, to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a licensed dentist for my child.

I further authorize Arlene Jones, or Becky Hessling, or Ben Forrester to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to any of them.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the supervisor or his/her authorized designee, in the exercise of his/her best judgment, upon advice of such physician, dentist, and surgeon, may deem advisable.

I agree that I am ultimately responsible for the cost of any medical care not reimbursed by my health insurance provider or if I do not carry any health insurance. I also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by Arlene Jones, or Becky Hessling, or Ben Forrester.

Dated _____

Signature of parent/guardian _____

Health Information

Medical/Health Insurance Company _____ Insurance Policy # _____

Allergies/Allergic reactions of my child

Medicine being taken by my child

Other information regarding my child's health that a doctor should know (write on back)

Please make a copy of your health insurance card and attach to this sheet. Thank you.