

**Valencia United Methodist Church**  
**MULTIJURISDICTIONAL AUTHORIZATION AND RELEASE**  
**FOR MEDICAL AND DENTAL TREATMENT**

I (we) the undersigned, as the parent or parents, or legal guardian or legal guardians, of \_\_\_\_\_, a minor, hereby authorize the Valencia United Methodist Church (VUMC) and its employees, directors and adult volunteers (collectively VUMC) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care (collectively "medical care") to be rendered to the minor under the general or special supervision and upon the advice of a physician or surgeon licensed under the laws of the state or jurisdiction in which medical care is sought, and to consent to any x-ray, anesthetic, dental or surgical diagnosis or treatment and hospital care (collectively "dental care") to be rendered to the minor by a dentist licensed under the laws of the state or other jurisdiction in which dental care is sought. For the purpose of medical, or dental care obtained outside of California, this authorization is given with the intent that any consent given pursuant to this authorization shall be the consent of each of the undersigned.

The undersigned understand and agree that VUMC shall not be legally or financially liable for any bill or medical expense incurred, or for any cause of action or claim arising from any medical care or dental care provided, or the lack of medical care or dental care. The undersigned hereby agree to indemnify, defend, and hold VUMC harmless from any claim made by or on behalf of the minor person or the minor's heirs or parents or guardians arising out of any medical care or dental care provided.

STUDENT'S NAME \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

ALLERGIES TO DRUGS OR FOODS: \_\_\_\_\_

LAST TETANUS TOXOID BOOSTER: \_\_\_\_\_

LIST ANY RESTRICTIONS: \_\_\_\_\_

TELEPHONE NUMBERS WHERE PARENTS MAY BE REACHED:

Father's Name	Home	Business	Cell
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Mother's Name	Home	Business	Cell
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Telephone number of responsible person whom we may call in the event parents cannot be reached.

Parent's Signature \_\_\_\_\_ DATE \_\_\_\_\_

Parent's Signature \_\_\_\_\_ DATE \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Expires \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephone \_\_\_\_\_

The VUMC requires that, if the minor is in the custody of both parents or more than one legal guardian, both or all sign this authorization. The VUMC understands that the minor is in the custody only of the person or persons who have signed this authorization.

This medical/dental release is in effect for the time period of July 1, 2008 through June 30, 2012 for all activities the above-named person participates in that are put on by or sponsored by VUMC.