

# October 2009—September 2010 MEDICAL AUTHORIZATION & RELEASE

(you must complete a medical authorization & release for each child)

I, \_\_\_\_\_, authorize the Designated Agents (as hereinafter defined) of Rolling Hills Community Church, 1810 Columbia Avenue, Franklin, Tennessee 37064 (the "Church"), to consent to, and to execute any and all documents necessary for, my child, \_\_\_\_\_ (the "Child"), to be treated by a medical doctor or a medical facility, whether on an emergency or non-emergency basis, if such care be determined necessary for his or her care, health and general welfare during any activity or event associated with the Church. For purposes of this Medical Authorization and Release, the "Designated Agents" are defined to be the following:

1. Nicholas Allen
2. Alex Derry
3. Meredith Cromer
4. Those persons identified as adult counselors and sponsors for an activity or event associated with the Church in an affidavit executed by any of the individuals listed above and presented with this Medical Authorization and Release at the time medical treatment is requested for the above-named Child.

My medical insurance carrier is \_\_\_\_\_; Policy/Group No. \_\_\_\_\_;  
Policy carried by \_\_\_\_\_.  
(Please attach a copy of the insurance card.)

My child's primary physician is \_\_\_\_\_; Phone No. \_\_\_\_\_.

(COMPLETE, IF APPLICABLE) I am either in active military service or am retired. My child is entitled to military medical care and my identification number is \_\_\_\_\_.

(COMPLETE, IF YOU ARE ON TENNCARE) I do not have medical insurance, but I authorize any necessary medical care to be charged to the following credit card account: (VISA) (MASTERCARD) (DISCOVER) (AMEX):  
Account No: \_\_\_\_\_. Expiration Date: \_\_\_\_\_.

\_\_\_\_\_  
**Parent or Guardian Signature**  
(For Credit Card Use Only)

\_\_\_\_\_  
**Date**

If necessary, I can be reached at the following phone numbers:

Residence: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Work: \_\_\_\_\_ Other: \_\_\_\_\_

**IMPORTANT!** Please complete the following information:

1. Does your child have any allergies? \_\_\_\_\_ Describe: \_\_\_\_\_

2. Any allergies to medicine? \_\_\_\_\_ Describe: \_\_\_\_\_

3. Does your child take any medication regularly? \_\_\_\_\_ Describe: \_\_\_\_\_

4. Does your child have any physical limitations? (asthma, diabetes, etc.)? \_\_\_\_\_

\_\_\_\_\_  
Date or Year of last Tetanus Shot \_\_\_\_\_

Special instruction in addition to above which might be helpful to physician (rare blood type, contact-lens wearer, etc.)  
\_\_\_\_\_

This authorization shall remain in effect, from this date until September 30, 2010, unless sooner revoked in writing by me. **I hereby release Rolling Hills and the Designated Agents from any claims, liabilities, demands, damages, rights and causes of action resulting or arising, directly or indirectly, from any consent or action taken by him or her pursuant to this Medical Authorization and Release.**

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Date**