# Medical and Image Release

## Participant Information

Event name: _____ Event date: _____

Participant's name: _____ Email: _____

Grade: _____ Church: _____

Address: _____ City/state/zip: _____

*Parent(s) / guardian(s)*

Name 1: _____ Name 2: _____

Preferred phone: _____ Preferred phone: _____

Email: _____ Email: _____

*In case of an emergency, where the above persons cannot be reached, please notify:*

Name: _____ Relationship: _____

City of residence: _____

Phone (day): _____ Phone (night): _____

**Medical Authorization**

I/we, the parent(s) or legal guardian(s) of _____, a minor, hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed medical personnel on staff of any licensed hospital. This authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority and power to render care, which is deemed advisable in the best judgement of the physician.

| Date: | Signature: | Relationship: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Sign Here**

Birthdate of minor: _____ Date of last tetanus shot: _____

Allergies: _____ Medications: _____

Special needs: _____

Physician: _____ Physician phone: _____

Insurance: _____ Policy #: _____

**Photo, Audio, and Video Release**

I give the Episcopal Diocese of California and _____ permission to take photographs, videotape, and/or record the voice of _____, a minor, and to use those images and recordings in Episcopal Church print and online publications only and following diocesan policies regarding social media.

| Date: | Signature: | Relationship: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Sign Here**