

LUTHERAN CHURCH OF THE INCARNATION  
1701 Russell Blvd, Davis, CA 95616 530-756-5500

**EMERGENCY MEDICAL TREATMENT AUTHORIZATION AND RELEASE**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
*Last First Middle mm/dd/yy*

Home Address \_\_\_\_\_  
*Street & Number City State ZIP*

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Parent or Guardian \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
*(if different than above) Street & Number City State ZIP*

Business Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
*Street & Number City State ZIP*

Other Parent or Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
*(if different than above) Street & Number City State ZIP*

Business Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
*(if different than above) Street & Number City State ZIP*

If not available during emergency, notify \_\_\_\_\_

Home Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
*Street & Number City State ZIP*

Health Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

**Photocopy of the front and back of health insurance card must be attached to this form  
Keep a copy of this form for your record.**

I authorize the emergency medical treatment of my minor child, \_\_\_\_\_,  
by the Lutheran Church of the Incarnation leader who deems the emergency medical treatment necessary, in his or  
her opinion, during a youth ministry sponsored activity. I also agree to release and hold harmless said leader who,  
administers and/or authorizes such emergency medical treatment. This authorization/release is to be in effect from  
September 1, 2008, to midnight September 1, 2009.

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

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