

FAITH  
CHAPEL  
STUDENT MINISTRIES

2009  
MINOR MEDICAL SHEET

student' name: \_\_\_\_\_

address: \_\_\_\_\_

[street]

\_\_\_\_\_  
[city] [state] [zip]

date of birth \_\_\_/\_\_\_/\_\_\_ city of birth \_\_\_\_\_

///parent-guardian

name: \_\_\_\_\_

home phone# \_\_\_\_\_

alternate phone# \_\_\_\_\_

///alternate emergency contact: \_\_\_\_\_

phone# \_\_\_\_\_

allergies, physical limitations, special health conditions, medications  
required, etc.:

\_\_\_\_\_  
\_\_\_\_\_

Doctors Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy#: \_\_\_\_\_

As the parent, agency representative, or legal guardian, I hereby give consent to Faith Chapel, and agents thereof to provide all emergency dental or medical care prescribed by a duly licensed physician [M.D.] or dentist [D.D.S.] for my child listed above. The care may be given under whatever conditions necessary to preserve the life, limb, or well being of my dependant. This authorization is given pursuant to the provisions of Section 25B of the Civil Code of California.

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

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