

CHILDCARE WAIVER

CHILD'S FULL NAME: _____

CHILD'S BIRTHDAY (e.g. mm/dd/yyyy): _____

ALLERGIES & SPECIAL NEEDS: _____

MOTHER'S NAME: _____

STREET ADDRESS: _____

PHONE NUMBER (Home): _____

PHONE NUMBER (Cell): _____

EMAIL ADDRESS: _____

AUTHORIZE TO CONSENT TO TREATMENT OF A MINOR

(I) (We) the undersigned, parent(s) of

(Print full name of minor)

a minor, do hereby authorize an agent of Bethel Church Women's Bible Study for the undersigned to 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 physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician/surgeon in the exercise of his/her best judgment may deem advisable. (I) (We) hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment.

These authorizations shall remain effect until May 1, 2011.

Date: _____

(Parent or Legal Guardian)

(Parent or Legal Guardian)