



**Church on the Hill**  
**700 NW Hill Rd**  
**McMinnville, OR 97128**  
**Phone: (503) 472-8476**

## 2019-2020 Medical Release—Youth Ministry

I \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_,  
Print Name of Parent or Legal Guardian Print Name of Minor

hereinafter referred to as “my child”, who was born on \_\_\_\_\_.  
Date of Birth (MM/DD/YY)

My child is attending and participating in youth ministry activities of McMinnville First Church of the Nazarene, hereinafter referred to as Church on the Hill, located at 700 NW Hill Rd, McMinnville, OR 97128, beginning the day of \_\_\_\_\_.  
Today's Date (MM/DD/YYYY)

I hereby authorize the Associate Pastor of Family Ministries and his/her representatives and partners, volunteer or employee, who are 18 years of age or older, who supervise and support youth ministry activities at Church on the Hill, into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent for my child to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of, or to be rendered by, a physician and surgeon licensed under the **Medical Practice Act**.

The authority granted by this authorization also includes the authority to consent for my child to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the **Dental Practice Act**.

### Additional Information:

<small>Parent/Legal Guardian</small>		<small>Email Address</small>		
<small>Street Address</small>		<small>City</small>	<small>State</small>	<small>Zip</small>
<small>Home Phone</small>	<small>Cell Phone</small>	<small>Work Phone</small>		
<small>Medical/Health Insurance Company</small>		<small>Policy No.</small>		
<small>Emergency Contact Name (outside of the home)</small>		<small>Phone Number</small>	<small>Relationship to Minor</small>	
<small>Allergies/Allergic Reactions of My Child</small>				
<small>Medicine Being Taken By My Child</small>				
<small>Other Information Regarding My Child's Health That A Doctor Should Know</small>				

It is understood that this authorization is given in advance of any special diagnosis, treatment or hospital care being required, but is given to provide the authority and power on the part of the Associate Pastor of Family Ministries and his/her designee to exercise his/her best judgment on what is advisable for my child's care, upon advise of such physician, dentist or surgeon.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Today's Date (MM/DD/YY)