Emergency Medical Release Form

In the case of an emergency, I, the undersigned volunteer or parent/guardian of a volunteer under 18 years of age, do hereby authorize Community Mission of Hope (CMOH) or its representatives to consent to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered under general or special supervision and upon the advice of a physician and/or surgeon licensed under the provisions of the **Medical Practice Act**, and to consent to any x-ray examination, anesthetic, dental, surgical diagnosis or treatment and hospital care to be rendered by a dentist licensed under the provision of the **Dental Practice Act**.

It is understood that this authorization is given in advance of any specific diagnosis treatment or hospital care being required. This authorization is given pursuant to the provisions of Section 25.8 and Section 34.6 of the Civil Code of California.

Emergency Contact Information:

_____	_____	(_____) _____
Emergency Contact Name	Relationship	Telephone
_____	_____	(_____) _____
Emergency Contact Name	Relationship	Telephone

Medical Information:

_____	(_____) _____	
Physician's Name	Telephone	
_____	_____	(_____) _____
Insurance Carrier	Policy Number	Telephone

Please list any allergies, including reactions to medication:

_____

_____

Please list any special needs, medical or other:

_____

_____

Please check or list any medical conditions CMOH should be aware:

(Check if applicable) ☐ Diabetic ☐ High Blood Pressure ☐ List Other: _____

_____

_____

_____ _____

Name of Volunteer (please print) Date

_____

Signature of Volunteer

_____ _____

Signature of Parent/Guardian Date
(If volunteer is under 18 years of age)