# AUTHORIZATION AND TREATMENT OF ADULT PARTICIPANT

____________________________
(Herein "Participant") (Print)

WORSHIP LIFE, INC. DBA LOVE SAN CLEMENTE
(Herein "Designated Agent")

The above-named Participant has entrusted their self into the care of Designated Agent, while the Participant participates in an activity sponsored by the Designated Agent, and for the welfare of the Participant.

The Participant does hereby authorize the Designated Agent 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 physician and surgeon licensed under the provisions of the California Medical Practice Act or of the laws of the State or Country in which the medical care is being sought and on the medical staff of any hospital; or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to the Participant by any dentist licensed under the California Dental Practice Act or the laws of the State or Country in which the dental care is being sought.

It is understood that this authorization is given in advance of any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the Agent to give specific consent to any and all such examination, anesthetic, diagnosis, treatment, or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable.

The Participant hereby authorizes any hospital, which has provided treatment to the Participant, to surrender physical custody of the Participant to the Agent upon the completion of treatment. This authorization is given pursuant to Section 1283(a) of the Health and Safety Code of California, and similar provisions of the laws of the state or country in which the medical or dental care is being provided. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and similar provisions of the laws of the state or country in which the medical or dental care is being sought. The Participant hereby agrees to fully pay all costs of medical or dental care incurred for the Participant by the Agent under this authorization. These authorizations shall remain effective until **December 31, 2016,** unless sooner revoked in writing delivered to said Agent.

________________________ ________________________________
Date Participant Signature

## MEDICAL INFORMATION

Insurance Company:____________________________________________
Claim Office Address:___________________________________________
Claim Office Telephone Number:__________ Policy #_________ Group #________
Employer Name and Address: ____________________________________
Emergency Contact:________________________ Telephone:_______________
Special Medical Conditions of Minor such as Diabetes, Allergic Reactions, Medications Currently Using:_____________________________________________
______________________________________________________________
Physician Name:_______________________ Telephone:__________________
Address:_______________________________________________________

## RELEASE FORM

I, ____________________________________________, am participating in the programs/events of WORSHIP LIFE, INC. DBA LOVE SAN CLEMENTE. I understand these programs/events occur both on WORSHIP LIFE, INC. DBA LOVE SAN CLEMENTE campus as well as other locations off campus. I hereby remise, release and forever discharge WORSHIP LIFE, INC. DBA LOVE SAN CLEMENTE, its employees, agents, servants and all other persons, firms and corporations whomsoever of and from any and all actions, claims and demands, whosoever which claimant now has or may hereafter have on account of or arising out of any accident, casualty and/or action which might happen while participating in programs/events. I further understand that there is no Worker's Compensation or Accident Insurance furnished by WORSHIP LIFE, INC. DBA LOVE SAN CLEMENTE for such programs/events. I acknowledge that I am responsible for any and all medical expenses of the above noted participant while participating in all programs/events, and agree to hold harmless WORSHIP LIFE, INC. DBA LOVE SAN CLEMENTE of any and all liability that may arise out of such participation.

________________________ ________________________________
Date Participant Signature

ADDRESS: ______________________________________________________

TELEPHONE: (Day)_______________ (Night)_______________EMAIL:___________________

DATE OF BIRTH: ____________________