SOUTHERN CALIFORNIA CONFERENCE
OF SEVENTH-DAY ADVENTISTS
1535 E. Chevy Chase Drive
Glendale, CA 91206
(818)-546-8415; Fax (818)-546-8475

AUTHORIZATION FOR MEDICAL TREATMENT FOR MINORS

I, ________________________ (*printed name of parent or guardian*) am the parent or legal guardian of ___________________________ (*printed name of minor*), referred to as "my child."

My child is attending and participating in activities at _______________________________________ Seventh-day Adventist Church, a part of the Southern California Conference of Seventh-day Adventists, located at ____

I authorize the Pastor and his or her church officers, agents, servants, or employees who are 18 years of age of older, who supervise the activities of this organization into whose care my child has been entrusted, to consent to medical or dental care, or both, for my child under Sections 6901, 6902, and 6910 of the California Family Code.

The authority granted by this authorization includes the authority to consent to any radiological (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 California laws or equivalent statutes of other states, for my child.

I further authorize the Pastor and his or her church officers, agents, servants, or employees who supervise the activities of the organization to receive physical custody of my child, under Section 1283(a) of the California Health and Safety Code, upon completion of any treatment, and I specifically instruct any treating health facility to surrender custody of my child to the Pastor and his or her church officers, agents, servants, or employees who are 18 years of age or older who supervise the activities at this organization.

I understand that this authorization is given in advance of any diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the Pastor and his or her authorized designee, to exercise his or her best judgment on what is advisable for my child's care, with advice of such physician, dentist, and surgeon. A photocopy of this shall be as valid as the original. This Authorization shall remain valid until revoked in writing.

The attached information sheet contains the complete and accurate health and emergency information and is for assistance in providing health care to my child.

___________________________________	_____________	_________________________
Signature of parent or guardian	Date signed	City and State where signed