



118 Neal Street ● Pleasanton, CA 94566 ● (925) 846-7220

## Medical Emergency Form

I \_\_\_\_\_, of \_\_\_\_\_  
*Parent or Guardian* *Street Address, City, Zip*

do appoint \_\_\_\_\_ of Lighthouse Baptist School, Lighthouse Baptist Church, Pleasanton, CA to make emergency medical decisions for my child \_\_\_\_\_ in the event that I cannot be reached at the telephone number listed below.

In the event of an emergency, if I cannot be reached, my appointee has authority to consent to or refuse treatment on my child's behalf, and to arrange medical services for my child, including admission to a hospital. If my child has medical conditions which may be relevant to a physician in the event of such an emergency, I have listed them below.

I understand and hereby agree to assume all financial obligations which are incurred in connection with such emergency medical decision. I do hereby agree to hold Lighthouse Baptist School, Lighthouse Baptist Church, and their agents and employees, harmless from any and all liability, actions, causes of actions, claims, expenses, and damages, even injury resulting in death, which I now have or which may arise in the future in connection with such emergency medical decisions.

I expressly agree that this release, waiver, and indemnity agreement is intended to be broad and inclusive as permitted by the law of the state of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This release contains the entire agreement between the parties hereto and the terms of this release are contractual and not a mere recital.

I further state that **I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND I SIGN THIS RELEASE AS MY OWN FREE ACT.** This is a legally binding agreement which I have read and understood.

Medical Conditions to be aware of:

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Medications my child is taking:

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Telephone number where I may be reached in an emergency: \_\_\_\_\_

Medical insurance information: \_\_\_\_\_  
*Insurance Carrier*

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*Identification Number*

*Insurance Carrier Number*