NORTHWEST CHAPEL

6700 Rings Road, Dublin, OH 43016

614-761-0363

ADULT MEDICAL CARE AUTHORIZATION RELEASE

I, the undersigned, hereby authorize any staff or team member of the Northwest Chapel Grace Brethren Church ministry team to cause a duly authorized and licensed physician or dentist to administer medical, dental, and/or surgical treatment at any time when such authorized personnel believe an emergency exists should I experience any illness or accident while traveling with the missions team. This authorization is intended to cover examinations, immunizations, injections, minor operations and procedures, and any necessary anesthetics. It is not intended that any medical or surgical treatment will be rendered without my personal consent. In the event of indicated major surgery, an attempt to contact my next of kin will be made before relying upon this authorization.

_____

PRINTED NAME

_____ _____

SIGNATURE DATE

NOTARY ACKNOWLEDGEMENT

State of _____

County of _____

On this the _____ day of _____, 20___ before me, a Notary Public for the State of _____, personally appeared _____, and proved to me on the basis of satisfactory evidence to be the person whose name was subscribed to the within instrument, and acknowledged that he/she executed it.

WITNESS my hand and official seal.

_____

NOTARY PUBLIC