Medical Release

In presenting my son/ daughter for diagnosis and treatment, I _____ (parent/legal guardian) for _____(child) of _____ years of age, give voluntary consent to the rendering of such care, including: diagnostic procedures, surgical and medical treatment, and blood transfusion, by authorized members of the hospital staff or their designees, as in their professional judgment be necessary.

I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my child's condition.

I have read this form and I understand its contents.

I give my consent to Peniel Holiness Camp Meeting Association, who will be caring for my child for the period of February 15, 2025 to February 16, 2025 , to arrange for routine or emergency medical, surgical, or dental care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature_____ Date:_____