Bent Tree Mission Journey

MEDICAL RELEASE FORM

I _____ the undersigned listed below, do hereby authorize any necessary examination, anesthetic, dental, medical or surgical diagnosis or treatment by any duly licensed physician or dentist and hospital service that may be rendered to me under the guardian, specific, or special consent of the temporary custodian of me; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a licensed hospital. I authorize the physician or dentist to call in any necessary consultants at his/their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. It is further understood that those persons who have temporary custody of me will attempt to talk with the emergency contact via the telephone numbers listed below before treatment is rendered.

<table>
<tr><th colspan="2">SIGNATURES</th></tr>
<tr><td colspan="2">I have fully read the above and understand it. Please sign below.

Printed Name: Signature:</td></tr>
<tr><td colspan="2">Emergency contact name and number:</td></tr>
<tr><td colspan="2">Parent or Guardian Name and phone # if team member is under 18</td></tr>
<tr><td colspan="2">Parent or Guardian Signature:</td></tr>
<tr><td>Date Signed:</td><td>Mission Journey:</td></tr>
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