二零二五年美加西岸基督徒追求聚會
父母/監護人同意書
及醫療表格

2025 WEST COAST CHRISTIAN CONFERENCE
PARENT/GUARDIAN CONSENT
AND MEDICAL FORM

日期：七月二十三至七月二十七日，二零二五年（週三-週日）　Date: July 23-27, 2025 (Wednesday –Sunday)
地點：加州三藩市州立大學　Place: SFSU, San Francisco, CA

未滿十八歲且父母親或法定監護人不能一同赴會之弟兄姊妹請在報名時附上此同意書。每位未成年人一張表格。
For participants under age 18 who will not be accompanied by their parent/legal guardian, please have their parent/legal guardian complete this form. One form per minor.

我 _____ 允許我的孩子 _____ 參加二零二五年美加西岸基督徒追求聚會。在聚會期間（七月二十三至七月二十七日）由下列一同赴會之弟兄/姊妹擔任其監護人。

I, _____, hereby give my child _____ permission to attend the 2025 West Coast Christian Conference from July 23 to 27. The following adult, also attending the Conference, will act as his/her guardian during the conference.

監護人姓名 Acting guardian's name: _____

監護人在何處聚會 Acting guardian's assembly's name: _____

監護人手機 Acting guardian's cell: _____

父母手機 Parent's Cell: _____

若有緊急事情請聯絡下列人員 Emergency contact:

姓名 Name: _____ 家屬關係 Relationship: _____

電話 Phone: 家 Home: _____ 手機 Cell: _____

簽名 Signature: _____ 日期 Date: _____

(父母或法定監護人 PARENT/LEGAL GUARDIAN)

填妥後請在七月一日之前以電郵或郵寄方式寄回。Please submit via email or mail by July 1.
電郵地址 email address: registration@westcoastchristianconference.com
郵件地址 mailing address: 1411 Hillcrest Blvd, Millbrae, CA 94030

二零二五年美加西岸基督徒追求聚會

父母/監護人同意書

及醫療表格

2025 WEST COAST CHRISTIAN CONFERENCE

PARENT/GUARDIAN CONSENT

AND MEDICAL FORM

Participating Child's Name: _____ Date of Birth: _____
參加之未成年人姓名 生日

I, (We), the undersigned, Parents or Guardians of _____minors, do hereby authorize WCCC and its representatives as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the medical practice act on the medical staff of any accredited hospital, when such diagnosis or treatment is rendered at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

本人（我們），下列簽名的，為_____的父母或監護人，特此授權WCCC及其代表作為我們的代理人,同意對上述未成年人進行任何X光檢查、麻醉、醫療或手術診斷或治療,以及醫院認為合適並由醫療法案規定的執業醫生及醫院醫療團隊全權管理的任何住院治療。我們理解此項授權是在未有任何特定診斷、治療或醫院照護需求之前提下給予的，目的是授予我們上述代理人特定同意權力及權限，允許代理人同意任何上述醫生在其最佳判斷下認為對於上述未成年人適宜的診斷、治療或醫院照護。

Allergies 過敏	Medical Limitations 醫療限制

MEDICAL INSURANCE CO: _____ Phone: ____ _____
醫療保險公司 電話

Member ID #: _____ _____ Group #: _____
會員編號 組別編號

PARENT/LEGAL GUARDIAN SIGNATURE: _____
父母或法定監護人簽名

DATE: _____
日期

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