AUTHORIZATION TO TREAT A MINOR

Student's name: _____ **Birthdate:** _____

Date of last Tetanus Toxoid Booster: _____

Allergies to DRUGS and/or FOODS: _____

_____

ANY Special Medications or Pertinent Information: _____

_____

Telephone Where Parents May be Reached:

Father's Name: _____ **Home:** _____ **Other:** _____

Mother's Name: _____ **Home:** _____ **Other:** _____

Family Physician: _____ **Telephone:** _____

Insurance Co: _____ **Policy No.:** _____

I do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

_____ _____

Signature of Parent/Legal Guardian **Date**

_____

Address **City** **State** **Zip**

This consent shall remain effective until: _____