AUTHORIZATION FOR TREATMENT OF A MINOR

Print Last Name, First Name

I (we) the undersigned parents(s) or legal guardian of:

_____minor(s), do hereby authorize and consent to any x-ray examination, anesthetics, 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 Medical 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 or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that efforts 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.

LIST ANY RESTRICTIONS:_____
BIRTHDATE(s):_____ LAST TETANUS/DIPHTHERIA:_____
(DPT) BOOSTERS:_____ ALLERGIES TO DRUGS OR FOOD:_____
_____

ANY SPECIAL MEDICATIONS OR PERTINENT INFORMATION:_____
_____

DATE:_____ _____
Signature of father, mother or legal guardian

_____ _____ _____ _____
Address City State Zip

****

PLACE OF EMPLOYMENT:_____ _____
Father or Guardian Mother

TELEPHONE NUMBER WHERE PARENTS OR LEGAL GUARDIAN CAN BE REACHED:

_____ _____ _____
Father (Guardian) Home Business

_____ _____ _____
Mother Home Business

TELEPHONE NUMBER OF RELATIVE OR FRIEND TO NOTIFY IN CASE OF EMERGENCY (other than parent or legal guardian):

_____ _____ _____
Relative/Friend Home Business

INSURANCE COMPANY(s) _____ _____
Name Policy Number

_____ _____ _____ _____
Expiration Date Verified by CRPD Agent's Name Phone Number

FAMILY DOCTOR:_____ _____
Name Phone Number

Additional adults who have your authorization to pick-up your child:

_____/_____ _____/_____
Name Phone Name Phone