Athletics Department

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/we, the undersigned parent(s)/guardian(s) of:

Minor _____ (_____) do hereby authorize any
Last, First Date of Birth

Physician on the staff of a licensed Hospital or Emergency Clinic, or any other physician designated by him (them) as agent(s) for the undersigned to consent to an 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 on the staff of a licensed Hospital of Emergency Clinic, whether such diagnosis or emergency treatment is rendered at the office of said physician or at said hospital(s). 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 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(s) in the exercise of his (their) best judgment may deem advisable.

This authorization shall remain in effect for the 2018 – 2019 school year or unless sooner revoked in writing and delivered to the school Principal.

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

_____ _____
Family Physician Physician's Phone Number

_____ _____
Health Insurance Company Group/ Policy Number

_____ _____
Signature of Father/Guardian Father/Guardian's Address & Phone Number

_____ _____
Signature of Mother/Guardian Mother/Guardian's Address & Phone Number

Indicate SPECIAL MEDICAL INFORMATION _____

_____

_____

_____

Person(s) to be notified in the event parent(s) or guardian(s) cannot be reached:

_____ _____
Name Address & Phone Number

_____ _____
Name Address & Phone Number