

**AUTHORIZATION FOR TREATMENT  
of a Minor**

\_\_\_\_\_ **print last name**

I (we) the undersigned parent(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 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.

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 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