

# AUTHORIZATION TO TREAT A MINOR

**Consent shall remain in effect until December 31, 2012**

Name of Minor: \_\_\_\_\_ Age: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Tetanus Booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies to food or drugs: \_\_\_\_\_

Medications used or other pertinent information: \_\_\_\_\_

List any restrictions: \_\_\_\_\_

\_\_\_\_\_(\_\_\_\_)\_\_\_\_\_(\_\_\_\_)\_\_\_\_\_  
Father's Name Home Phone Cell phone/Business

\_\_\_\_\_(\_\_\_\_)\_\_\_\_\_(\_\_\_\_)\_\_\_\_\_  
Mother's Name Home Phone Cell phone/Business

Physician: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_

Address: \_\_\_\_\_

Medical Ins Co: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I (we) the undersigned parent(s) or legal guardian of \_\_\_\_\_ a minor, 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 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 a 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 every possible effort shall be made to contact the undersigned prior to rendering treatment of the patient, but that any of the above treatments 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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE SIGNATURE OF PARENT OR LEGAL GUARDIAN

**Volunteer Position** \_\_\_\_\_

## PARENT DRIVER INFORMATION

**INSURANCE COVERAGE:** The amount of your coverage must meet or exceed the insurance requirement of the state in which the vehicle is licensed. It is recommended, however, that coverage limits are at least \$50,000/\$100,000/\$50,000 or \$100,000 combined single limit. If you do not meet these requirements, please do not volunteer as a driver.

### Driver #1

Name: \_\_\_\_\_ CA Driver's Lic #: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Year/Make/model of car: \_\_\_\_/\_\_\_\_/\_\_\_\_ # Seatbelts: \_\_\_\_\_

### Driver #2

Name: \_\_\_\_\_ CA Driver's Lic#: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Year/Make/model of car: \_\_\_\_/\_\_\_\_/\_\_\_\_ # Seatbelts: \_\_\_\_\_