Rev:May2006
Review June 2010

Sailor Name: _____ **School Name:** _____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

The undersigned parent or guardian of a minor does hereby consent to emergency X-ray, 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 licensed under the provisions of the Medical Practice Act, or dentist under the Dental Practice Act. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care which the aforementioned physicians in the exercise of their best judgment may deem advisable. It is understood that efforts shall be made to contact the undersigned or Emergency Contact prior to rendering treatment, but treatment will not be withheld if they cannot be reached.

1. Family Doctor: _____ Phone: _____

2. Emergency Contact: _____ Phone: _____

3. Medical Problems: _____

4. Known Allergies: _____

5. Hospital Insurance Plan Name/Number: _____
_____

SIGNATURE (Parent or Legal Guardian): _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Phone (h): _____ (w): _____ (c): _____

Father's Phone (h): _____ (w): _____ (c): _____