



# AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent(s) or legal guardian(s) 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 licensed under the provisions of the **Medicine 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 specified diagnosis, treatment of hospital care being required but is given to provide authority and power to render care which the aforementioned physician or dentist in the exercise of his/her best judgement 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.B of the Civil Code of California.

List of restrictions \_\_\_\_\_

This consent shall remain effective until \_\_\_\_\_

List all allergies to food, drugs, insects

\_\_\_\_\_  
\_\_\_\_\_

Have your child ever been stung by a bee? [ ] Yes [ ] No

Last Tetanus Booster \_\_\_\_\_

Special Medications of Problems \_\_\_\_\_

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

Phone Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Parent/ legal guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_