

### AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent, parents 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 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 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 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 6910 of the Family Code.

List any restrictions. \_\_\_\_\_

\_\_\_\_\_  
Date *Signature of Father, Mother or Legal Guardian*  
\_\_\_\_\_  
Address City State Zip  
This consent shall remain effective until, \_\_\_\_\_ 20\_\_\_\_

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BIRTH DATE \_\_\_\_\_ LAST TETANUS  
TOXOID BOOSTER \_\_\_\_\_

ALLERGIES to  
DRUGS or FOOD \_\_\_\_\_

ANY SPECIAL MEDICATIONS  
or PERTINENT INFORMATION \_\_\_\_\_

PARENTS'  
TELEPHONES: \_\_\_\_\_ ( ) \_\_\_\_\_ ( )  
Father Home Business  
Mother Home Business

FAMILY PHYSICIAN  
NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

INSURANCE  
COMPANY \_\_\_\_\_ POLICY NO. \_\_\_\_\_

Los Alamitos Unified School District - Form 477 6/81 -- WH. 0800B

BIRTH DATE \_\_\_\_\_ LAST TETANUS  
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ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

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