THE CREEK PRESCHOOL AND KINDERGARTEN

AUTHORIZATION TO TREAT A MINOR

I (WE) THE UNDERSIGNED PARENT OR LEGAL GUARDIAN OF_____ D.O.B._____, 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 AFORMENTIONED PHYSICIAN IN THE EXERCISE OF HIS BEST JUDEMENT MAY DEEM ADVISABLE. IT IS UNDERSTOOD THAT THE 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 ANY RESTRICTIONS:

_____

_____

SIGNATURE OF FATHER, MOTHER, OR LEGAL GUARDIAN:_____DATE_____

ADDRESS_____CITY_____STATE_____ZIP___

THIS CONSENT SHALL REMAIN IN EFFECT UNTIL_____

LAST TETANUS BOOSTER:_____

ALLERGIES TO FOOD OR DRUGS:_____

ANY SPECIAL MEDICATIONS OR PERTINENT INFORMATION:

_____

TELEPHONES WHERE PARENTS/GUARDIAN'S CAN BE REACHED:

FATHER'S HOME_____WORK_____ CELL_____

MOTHER'S HOME_____ WORK_____ CELL_____

PHYSICIAN'S NAME_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____

INSURANCE CO._____ POLICY & GROUP #_____