

ATHLETE'S FULL NAME _____ BIRTHDATE _____

AUTHORIZATION TO CONSENT TO TREAT OF MINOR

The undersigned parent or guardian of _____, a minor, do hereby consent to any emergency x-ray examination, 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.

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 on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the provisions of Section 6910 of the Civil Code of California.

1. Family Doctor and/or Associate: _____

Phone: (_____) _____

2. Persons to contact in emergency:

A. _____ Phone: (_____) _____

B. _____ Phone: (_____) _____

3. Medical Problems: _____

4. Hospital Insurance Plan and/or Medical Plan

This Authorization shall remain effective until revoked in writing.

Parent or Legal Guardian (Print): _____

Parent or Legal Guardian (Signature): _____

Address _____ City _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Parent's Social Security Number _____