

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned, parent(s) of \_\_\_\_\_, a minor, do hereby authorize **Coastal Grove Charter School** as agent for the undersigned to consent to any x-ray, examination, anesthetic, medical surgical diagnosis or treatment, and hospital care that 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 on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

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 the Coastal Grove Charter School to give specific consent to any and all such diagnosis, treatment, or hospital care that aforementioned physician in the exercise of his/her best judgment may deem advisable.

(I) (We) hereby authorize any hospital that has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to the Coastal Grove Charter School upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

These authorizations shall remain effective through **June 14, 2012**, unless sooner revoked in writing delivered to the Arcata School District.

\_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian Signature

Child's Birthdate: \_\_\_\_\_ Doctor \_\_\_\_\_ Dentist \_\_\_\_\_

Chronic Illnesses: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_ Date/Last Tetanus: \_\_\_\_\_

Name & No. of Med. Insurance Policy: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

**Please return this consent form to your child's school office. This form will only be used in case of an emergency.**