ESCONDIDO CHRISTIAN SCHOOL

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(I), (We), the undersigned, parent(s) of _____, grade_____, birth date_____ (minor), do hereby authorize the hospital most accessible during the time of accident or illness to any 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 Medicine Practice Act on the medical staff of said hospital, whether such diagnosis, or treatment is rendered at the office of said physician or at said hospital. THIS ACTION WOULD NOT BE TAKEN UNLESS THE PARENTS COULD NOT BE REACHED.

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 aforementioned agent(s) to give specific consent to any and all such physician in the exercise of his best judgment may deem advisable.

This authorization shall remain in effect for the _____ school year unless sooner revoked in writing to the school. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Dated _____ e-mail address _____

Mother's Name _____ Mother's Work Phone(____)_____
Cell/Pager # (____)_____

Father's Name _____ Father's Work Phone (____)_____
Cell/Pager # (____)_____

Doctor _____ Phone (____)_____

Other Emergency Contacts **Please Note: Anyone listed below would be contacted if a parent was not available. They would be authorized to pick up your child from school or Day Care. In the event of an emergency or disaster, your child would be released *only* to the individuals listed below.

Name _____ Name _____ Name _____

Phone(____)_____ Phone(____)_____ Phone(____)_____

Church Home _____

_____ (____)_____
Signature of Parent or Guardian Home Phone

_____
Mailing Address City Zip