

Bethel Lutheran Youth

Authorization to treat a minor (United States, Canada and Mexico)

I (we), the undersigned parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to a any X-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or specific supervision of any member of the medical staff and emergency room staff licensed under the provisions of the state or province Medicine Practice Act or a dentist licensed under the provisions of the state or province Dental Practice Act and/or the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health, or the state or province in which the hospital is located.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given provide authority and power to render care which the aforementioned physician in the exercise of his best judgement may deem necessary.

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 25>8 of the Civil Code of California.

List any restrictions: _____

This consent shall remain effective for 1 year from this date: _____

Signature of Father, Mother, Legal Guardian

Address City Zip

This consent shall be extended by one year by initialing and dating: _____

_____, _____

| | | |
|---|----------|-----------|
| NAME _____ | | |
| BIRTHDATE _____ | | |
| LAST TETANUS TOXOID BOOSTER _____ | | |
| BLOOD TYPE _____ | | |
| ALLERGIES TO DRUGS OR FOOD _____ | | |
| ANY SPECIAL MEDICATIONS OR PERTINENT INFORMATION _____ | | |
| TELEPHONE WHERE PARENTS MAY BE REACHED: | | |
| FATHER: HOME: _____ | | |
| WORK: _____ | | |
| CEL: _____ | | |
| MOTHER: HOME: _____ | | |
| WORK: _____ | | |
| CEL: _____ | | |
| EMERGENCY PHONE #: _____ | | |
| NAME: _____ | | |
| RELATION: _____ | | |
| FAMILY PHYSICIAN: _____ | | |
| _____ | | |
| Address | City | Zip |
| INSURANCE COMPANY: _____ | | |
| POLICY NUMBER: _____ | | |
| HAS YOUR CHILD BEEN TREATED FOR ANY OF THE FOLLOWING? | | |
| Rheumatic Fever | No _____ | Yes _____ |
| Heart Disease | No _____ | Yes _____ |
| Chronic Lung Disease | No _____ | Yes _____ |
| Asthma | No _____ | Yes _____ |
| Chronic Ear Disease | No _____ | Yes _____ |
| Disease of the Bone or Joints | No _____ | Yes _____ |
| Epilepsy | No _____ | Yes _____ |
| Other | No _____ | Yes _____ |
| HAS THE CHILD ANY KNOWN DEFECT OF VISION OR HEARING No _____ Yes _____ | | |
| Explain: _____ | | |
| DOES THE CHILD WEAR GLASSES OR CONTACT LENSES OF ANY KIND? No ___ Yes ___ | | |
| DATE OF LAST PHYSICAL EXAMINATION: _____ | | |
| _____ | | |
| Month | Year | |