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 Heath, 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, buy t hat 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