California Lutheran High School

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(951) 678-7000 (voice)
(951) 678-0172 (fax)

Form C - Authorization to Treat a Minor (2016-2017)

I (we the undersigned parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable . 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 the Section 25.8 of the Civil Code of the State of California. I (we) further give my permission to persons designated by the California Lutheran High School administration to dispense prescription or non-prescription medication on my behalf to _____ and I release California Lutheran High School from all liability.

Allergies to food: (please state the severity of the allergy and reaction)

_____

_____

Allergies to drug: (please state the severity of the allergy and reaction)

_____

_____

_____

Current Medications and dosage: (please state times when the meds are taken)

_____

_____

_____

Other pertinent Health Information:

_____

_____

Please Attach a Copy of Your Medical Insurance Card. Thank You!

(Please see back)

Student's full name _____ Date of Birth _____

Current age _____ Date of last tetanus toxoid booster _____

Father's full name/Legal Guardian _____ Date of Birth _____

Mother's full name/Legal Guardian _____ Date of Birth _____

Signature of Father/ Legal Guardian _____ Date _____

Signature of Mother/ Legal Guardian _____ Date _____

Address _____

City _____ State _____ Zip code _____

Cell/Home Phone (_____)_____ Number to call in case of emergency (_____)_____

Place of Employment – insured parent _____ Work Phone (_____)_____

Insurance Company _____ Phone Number (_____)_____

Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Group Number _____

Family physician _____ Phone Number (_____)_____

Address _____

City _____ State _____ Zip Code _____